Practice change and development: an insider view- a grounded theory study on the nature of nursing practice change

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy by Linda Meredith

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Declaration by candidate

I hereby declare that this thesis is my own work and effort and that it has not been submitted anywhere for any award. Where other sources of information have been used, they have been acknowledged.

Signature:

Date: 10/5/2012

Dedications

I am dedicating this work to the following people:

My dear late husband, who could always be relied upon for support and encouragement in times of need.

Charlie and Caroline who have put up with a part time mother for so many years.

My supervisors for their patience, skills and constant enthusiasm:

The late Professor Tom Mason

Dr Steve Fallows

A special thank you to Professor Mike Thomas who stepped into the breach at short notice and inspired me to complete this work

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ABSTRACT

Change is a common feature of nursing, influenced by prevailing governments as part of their political agendas. These changes have impacted both on the context within which nursing takes place as well as on the actual role of the nurse. For change agents who are implementing these changes, it is imperative that they are aware of how nurses respond to change in order that they can plan the most effective strategies. This thesis investigated how nurses understand their own practice changes, the process that they undergo, how resistance to change manifests and if nursing rituals have an impact on the process. Finally the thesis made recommendations based on the findings to facilitate effective practice change and development.

The study was conducted in two parts. In-depth interviews with eight nurses from one acute NHS Trust made up the first part of the study. A further two interviews were conducted with eleven mental health nurses from an early intervention team in one NHS Mental Health Partnership Trust, and this constituted the second part of the study. Constructivist grounded theory was the research method employed in the design of the study. An underpinning theoretical framework of structural anthropology with specific reference to the work of Levi-Strauss was used to present the final grounded theory.

The study found that nurses understood the process of practice change as a spiral with the most significant aspects of practice change at the bottom. These were the day-to-day changes that may or may not lead to permanent change. At the top of the hierarchy and of least significance were the changes imposed by their employing organisations or nationally. The overall personal process of practice change and development was identified from the study as a process that centres on the experiences that participants have in their workplace, a process of sense making, learning and intuition. A Practice Change Model in the form of a continuum was developed that described how nurses respond to practice change and development.

The significance of this study is that the thesis was able to identify strategies for promoting effective practice change and development, aimed at nurses in practice, change agents at an organisational and national level, and the clinical link role within higher education.

CHAPTER 1

INTRODUCTION

1.0 Introduction

Change is a common feature of the Health Service and nursing. Since its inception in 1948, the Health Service has been subject to unprecedented restructuring influenced by prevailing governments as part of their political agendas (Bradshaw, 1995). Significant aspects of nurses' roles and responsibilities are subject to ongoing change as a result of these agendas. Nurses' practice care takes place on a daily basis within this context of change and uncertainty.

The focus of this study is to investigate nursing practice change from the perspective of the practising nurse. In order for managers to support high quality clinical care they need an understanding of the personal processes that nurses undergo during practice change and development. This includes knowledge on which aspects of practice change nurses consider are the most significant, the process if there is one, and an awareness of the factors that promote and cause resistance to change at both organisational and personal levels, in order to effectively inform change strategies.

This introduction will provide an outline of the research framework, and introduce the content of the chapters.

1.1 Outline of the research study

This research used constructivist grounded theory approach which was identified by Charmaz (2000a) as having an underpinning perspective of a symbolic interactionism alongside constructivist methods (Charmaz, 2002).

Constructivist grounded theory is based on the following assumptions: multiple realities exist, data reflect both the researcher's and participants' mutual constructions, and the researcher enters and is affected by each participant's world. Therefore the results become an interpretative portrayal of the studied world, not an exact picture of it (Gubrium & Holstein, 2002). This means that the

researcher aims to discover participants' implicit meaning of their experiences during their practice change and build a conceptual analysis of them, which are, in their own right, constructions of reality.

The underpinning theoretical framework of this study was structural anthropology with specific reference to the work of Levi-Strauss. Structural anthropology is a branch of anthropology that studies how people behave whilst in their social groups. The main focus of studies are their customs, economic and political organisations, kinships, family structure and religion (Rapport, 2000). The thesis will specifically refer to Levi Strauss's work on bricoleur and relate it to change and nursing practice.

Purposive sampling was used to select participants for the study. Sample selection was informed by prior knowledge of the services in which the participants worked and theoretical work undertaken during the literature review. Two groups of nurses were invited to participate; nurse champions working within a large NHS Trust Hospital and nurse members of Early Intervention Teams within an NHS Partnership healthcare provider organisation. A participant information sheet was sent to the total sample, and participation was based on self-selection.

This study was conducted in two parts. In-depth interviews with eight nurses from one acute NHS healthcare provider organisation made up the first part of the study. The nurses had been assigned the role of Nurse Champions for Older People which was an addition to their existing responsibilities. The healthcare provider organisation identified the role as part of the requirements from the National Service Framework (NSF) for Older People (Department of Health, 2001b) and the participants were receiving professional development as part of this role.

In-depth interviews with eleven mental health nurses from an early intervention team in one NHS Mental Health Partnership healthcare provider organisation constituted the second part of the study. Results from the analysis of the first part of the study were used to inform the content of the interviews in the second part. The members of the early intervention team were also interviewed a second time

in order to investigate their responses to a change of practice that was imposed upon them.

1.2 Overview of the thesis

The following is a chapter by chapter introduction to the content of the thesis.

1.4.1 Chapter 2 is the literature review which will address the broad areas that pertain to this study. There is minimal literature or research that addresses how nurses' practice changes over time, the process that nurses undergo as part of these changes, and factors that influence the changes. One of the assumptions made by the researcher is that nursing rituals might be one of the influencing factors on change, or even one of the resistors against change, and rituals will be explored during the research process. Consequently the broad subject areas that will be presented in the literature review are how practice can be defined as the area of change in question, what the literature says about change, resistance to change, and individual responses to change. This chapter will also explore nursing rituals, how they impact on nursing practice, and if they have any influence on practice change and development.

1.4.2 Chapter 3 addresses the development of the research questions from the aims of the study. The chapter will include the context within which the study takes place, and how the literature review contributed to the formulation of the research questions.

1.4.3 Chapter 4 addresses the research design and methods that underpin this study. The chapter will delineate the research paradigm and define the nature of the grounded theory approach to be taken. Collecting and managing the data, and how rigour is ensured throughout the research process, will be discussed along with the ethical considerations.

1.4.4 Chapters 5, 6 and 7 are the findings that result from analysis of the data. Chapter 5 is entitled 'The real world of practice change and development' and explores how nurses perceive that their practice changes and develops, and the influencing factors that impact on this process. The discussion will include an

analysis of how participants perceive that their practice actually changes, leading to a hierarchy of practice change. The chapter will also include an examination of nurses' attitude to practice change and development, identifying the differences between their responses to imposed change and changes in their practice that they themselves implement. The chapter will conclude with a model of practice change based upon participants' attitudes built up from the previous analysis and presented as a continuum.

Everyday clinical experience is the cornerstone of participants' working lives and this is the subject of Chapter 6. The majority of participants interviewed within this study identified this experience as the one overwhelming feature that impacted on their practice, and was the most significant influence on how they functioned on a day-to-day basis. The role and nature of experience in nursing has not been well documented, with only three available references that directly relate the nature of nursing experience (Arbon, 2004; Radwin, 1998; Watson, 1991). This chapter will explore the nature of experiences that participants in the study identified as impacting on their practice and leading to some sort of change. Becoming experienced as a nurse can be defined as 'a progressive and continuous interaction between experience, meaning and the lived world resulting in a personal and unique understanding of practice' (Arbon, 2004, p. 50). Chapter 6 will also explore how being experienced impacts on their practice change leading to a continuum that builds upon how nurses respond to change of practice, and the source of knowledge that they access to underpin their everyday working life. The experiences that nurses have and how they interpret them are influenced by their own personal and professional values, so this chapter will also explore the participants' personal and professional values and how they impact on practice change.

1.4.5 Chapter 7 will examine how participants make sense of their practice change, turning to significant other professionals in the workplace, both on a one-to-one basis and as part of the supervisory process. Linked to supervision is the process of reflection, and how this influences practice change will be explored. As with

previous chapters a continuum will be identified and a collated version will conclude the chapter.

1.4.6 Chapter 8 is the discussion chapter that will bring together all of the findings of chapters 5, 6 and 7, and locate them in relation to the literature review and the underpinning theoretical framework of structural anthropology. The overall grounded theory of practice change will be presented in this chapter.

1.4.7 Chapter 9 will conclude the thesis and will discuss to what extent the research questions have been met and discuss limitations of the study, with suggestions as to how the research could be taken forward. The chapter will reflect on the significance of the study's findings and make recommendations for the effective promotion of practice change for nursing managers, educationalists and practising nurses.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

There is contention between traditional and evolved grounded theorists as to the treatment of the literature when undertaking a grounded theory study. Traditionalists would say that reviewing the literature in advance leads to 'contaminating, constraining, inhibiting, stifling or impeding the researcher's analysis of codes emergent from the data' (B G Glaser, 1992, p. 31). The traditionalist would advocate undertaking a literature review after completion of data collection and analysis and the construction of the theoretical framework. The rationale for this is that the emergent theory will be more grounded in the data if the researcher comes to the process without any pre-conceived ideas (Cutcliffe, 2000). Embedding the use of literature into data collection, analysis and the generation of theory completes and enriches the research and is used to add a new dimension to the findings. As Stern (2007) suggests, 'it is important to situate your work within the body of related literature, both because it is academically honest to give credit to other researchers, and because you need to demonstrate how you built upon it so that you can see further' (Stern, 2007, p. 123).

Taking a pragmatic perspective, academic institutions, research funding councils and ethical committees all require the research questions and methodology to be informed by a sound literature review that facilitates conceptual clarity (Cutcliffe, 2000). It is not feasible to undertake a study that leads to an award without undertaking a literature review. To date a literature review has been presented to various committees four times during the compilation of this study. The topic area for this study arose from a nursing background and teaching interests resulting in an existing body of knowledge around the subject area. This existing knowledge adds to the development of theoretical sensitivity and will be supplemented by familiarity with the relevant literature.

Positive reasons for undertaking a literature review prior to data collection and analysis are that it is useful as an orientating process (Urquhart, 2007) and leads to

an awareness of the current thinking in the field. Urquhart (1999) suggests a compromise as a way forward, and this is to undertake a review of broad aspects associated with the identified research problem and organise broad categories of literature around those issues. This study will follow this model and will investigate the broad areas that relate to the topic of interest that is practice change and development.

The broad areas that this study is investigating are how nursing practice changes and develops over time; how nurses make sense or understand this change and the process that they undergo; and factors that influence the change. It is thought that nursing rituals might be one of the influencing factors on change, and for this reason are included in the study. Consequently the broad subject areas that will be addressed in this literature review are: how practice can be defined as the area of change in question; and what the literature says about change and resistance to change, focusing on resistance to the use of research in practice and individual responses to change. This chapter will also explore nursing rituals and how they impact on nursing practice, and if they have any influence on practice change and development.

2.1 Scope of the literature search

The literature search strategy that informed the production of the literature review was to address the broad areas identified in the initial aims and objectives of the study with a view to developing the embryonic research questions. For the most part literature related to nursing was accessed but for the subject of 'change and resistance to change' management literature was more appropriate.

Literature published in English was searched by accessing University local library sources and the inter-library loans. The search was indexed by the subjects of nursing, health, management, and philosophy and using the key words nursing, nursing rituals, management of change, barriers to research utilisation and practice development as the guiding search criteria.

Primary literature sources were accessed at all times. Cross-referencing of citations yielded a rich source of information. Google Scholar was accessed but was found to be of limited use.

The following databases were utilised:

Databases

1. Academic Search Complete (EBSCO)
2. ProQuest
3. CINAHL Plus
4. Education Research Complete (EBSCO)
5. Emerald
6. Ingentaconnect
7. MEDLINE
8. PsycINFO (EBSCO)
9. PubMed
10. ScienceDirect
11. SwetsWise
12. Web of Knowledge (Web of Science)
13. Wiley Online Library
14. Zetoc

Nursing is an international activity and many of the underpinning nursing practices may be similar irrespective of differences in country of origin, educational contexts and specialities. Therefore literature was accessed and cited from a number of studies which originate outside of the UK to supplement british sources. This provides a level of objectivity and an overview of the complex nature and context of the issues and factors relevant to the project.

2.2 The nature of nursing practice

This study is investigating how nurses perceive their practice changes and develops over time, and this section will review the seminal literature on what constitutes the aspects of nursing practice that could realistically change or develop. Nursing

practice has been investigated and represented in the literature from a variety of perspectives, and these will be addressed in the literature review including the underpinning knowledge base; knowing in nursing; and nursing as an art.

2.2.1 Knowledge for practice

The knowledge that underpins nursing practice has been of concern to the profession since the time of Florence Nightingale in the mid to late 19th century (Easterbrooks, et al., 2005) when she was credited with the identification of numerous volumes of epidemiological evidence gathered from her experiences of the Crimean War (1854). Since her work on nursing practice itself there has been further exploration over the last century and a half on underlying nursing theory (Henderson, 1966; Orem, 1991; Roper, 2000). When exploring the nature of nursing practice it is important to take into account the underlying knowledge base as the two are inexplicably linked. Research into knowledge that underpins practice has highlighted some commonalities between the categories of knowledge identified (C L. Clarke & Wilcockson, 2002; Easterbrooks, et al., 2005; S. Mantzoukas & Jasper, 2008). Clark and Wilcockson (2002) suggest that knowledge that underpins nursing practice can be divided into two categories: knowledge for practice (distal knowledge), and knowledge from practice (proximal knowledge).

Distal knowledge is generated from outside of practice, is typically evidence and/or research based, and is referred to as 'knowledge for practice' (C L. Clarke & Wilcockson, 2002). Generally service users are the subjects of research that generates distal knowledge, the results of which are prescriptive, and practitioners take less ownership of this type of knowledge (Winch, Henderson, & Creedy, 2005).

Proximal knowledge, on the other hand, is knowledge that is generated from a specific care environment by practitioners themselves and is heavily influenced by the contextual issues within that environment (Winch, et al., 2005). Examples of influencing factors include staffing levels, type of speciality and culture of the organisation. Clarke and Wilcockson (2002) suggest that proximal knowledge is not necessarily better than distal knowledge, and cite an example where the personal beliefs or proximal knowledge of some practitioners might actively promote

discriminatory care as it is context driven. Individual clinical expertise has been identified as being underpinned by proximal knowledge (Winch, et al., 2005) and although this form of knowledge is not necessarily informed by an evidence base or able to be generalised across nursing, it does engender a strong sense of ownership by the practitioner (Clark & Proctor, 1999). Proximal knowledge is influenced by experience: each new experience impacts on how the individual perceives the world and their interpretation of future experiences, and therefore proximal knowledge is in a continual process of change.

2.2.2 Patterns of knowing within knowledge

The ontological foundations of nursing over the past twenty years have shifted gradually from a focus on health and illness, as evidenced by the medical model with an emphasis on disease process, towards knowledge that is based upon human experience. Knowing is 'ways of perceiving and understanding the self and the world' (P Chinn, 1999, p. 1), and knowing in nursing is knowledge that has evolved from personal and professional experience in everyday life (S. Mantzoukas & Jasper, 2008). Within any body of knowledge there are patterns, forms and structures that guide ways of thinking about the phenomenon under study; in this case, patterns of knowing are ways of describing the knowledge that guides nursing practice, and each pattern is a 'dimension of the whole or total epistemology of nursing' (Averill & Clements, 2007, p. 390).

Schon (1983) identifies practical professional knowledge as knowing in action, and argues that as well as practice 'know how' there is also tacit or hidden knowledge. Eraut (1994) develops the concept of hidden knowledge further by differentiating between propositional knowledge (knowing that), which is knowledge that underpins practice, and practice know how. This practice know how is embodied within evidence based practice and positivist knowledge. Eraut (1994) suggests that professionals use personal or action knowledge to underpin their practice, and this forms part of their professional judgement.

There is also public knowledge that is found in publications and professional programmes. Easterbrooks et al (2005) supported this finding in their research

when they found other sources of public knowledge, which they termed documentary sources, that included the internet and unit based sources such as patients' charts and policy and procedure manuals. They agreed that only a limited amount of this public knowledge is actually incorporated into professional practice, whereas personal or action knowledge is utilised automatically.

Schon (1987) states that nursing practice is actually characterised by uncertainty, disorder and indeterminacy, and he describes nursing practice as having two dimensions. The first is the high, hard ground, where a positivist approach is appropriate, problems are manageable and where research based theory might be applied. The opposite to this high, hard ground are the swampy lowlands where 'messy, confusing problems defy technical solution' (Schon, 1987, p. 3). The most important challenging problems occur in the swampy lowland of practice as confusing messes.

One of the seminal works on knowledge that underpins nursing practice is the Fundamental Patterns of Knowing (Carper, 1978). Carper (1978) identified four patterns of knowing in nursing: empirics, or the science of nursing; aesthetics, or the art of nursing; ethics, which is the moral knowledge applied to nursing; and personal knowledge, which is concerned with self-awareness and the impact on others. These patterns do not stand in isolation; they arise from the whole experience of nursing and are interrelated. The experience of practice as well as education and research contribute to this development of nursing knowledge.

Empirics, the science of nursing, is the knowledge that is accessible through the senses – the scientific principles, facts, laws and quantifiable evidence that underpin practice and are generally observable (Averill & Clements, 2007). Clinical examples of empirics include routine observations such as blood pressure, pulse and respiratory rates. Mantzoukas and Jasper (2008) describe this type of knowledge as theoretical knowledge. The development of empirical knowledge traditionally has been through quantitative research, although lately inductive methodologies such as phenomenology, ethnography and grounded theory have

been accepted within the academic and nursing communities (P. L. Chinn & Kramer, 2004).

The aesthetics or the art of nursing is a metaphoric term that illustrates how nurses can offer the highest standard of care. Aesthetic knowing goes beyond using evidence to underpin practice and includes a deep appreciation of the meaning of a situation, including learning from experience, and is reflected through the actions, conduct, attitudes and expressions, narratives and interactions of the nurse in relation to others (Averill & Clements, 2007; P. L. Chinn & Kramer, 2004). The art of nursing will be explored further later in the chapter.

Personal knowing is the 'inner experience of becoming a whole, aware, genuine self' (P Chinn & Kramer, 1999, p. 5). This knowledge is gained from being personally involved in situations and experiences in practice. Person knowledge is knowing a person as an individual, understanding their personal experience of illness and care delivery (Liaschenko & Fisher, 1999). Easterbrooks et al (2005) term this type of knowledge as experiential, and Mantzoukas and Jasper (2008) as personal practice knowledge. They all agree that nurses favour this type of knowledge over empirical or distal knowledge.

Ethical knowing focuses on the moral components of nursing and what is the best and most responsible course of action to take (Averill & Clements, 2007). These include the ethical codes, standards and theories that underpin nursing practice. Ethical knowing is expressed in nursing actions and can offer insight into available options and subsequent choices made.

Two further patterns of knowing have also been identified: unknowing and socio-political knowledge. Munhall (1993) and Heath (1998) identify unknowing as an awareness that the nurse cannot know or understand the patient when they first meet, and by being open to new ideas can gain an insight into the patient's perspective. The key to unknowing is the openness of the nurse who puts aside subjective reality and is able to appreciate the world from the patient's view point (Heath, 1998). Unknowing can be related to all patterns of knowing (Heath, 1998). Identifying a lack of relevant empirical knowledge related to the situation might

lead the nurse to seek further information that will impact on practice. Ethical knowing is expressed through codes of conduct and standards, and unknowing might allow the nurse to accept that some moral dilemmas have to be lived with whereas others can be resolved or ameliorated (Jacobs-Kramer & Chinn, 1988). White (1995) adds socio-political knowledge to Carper's original patterns of knowing. This includes political, cultural, historical, economic, geographic and social key factors that need to be considered as part of nursing practice. These issues are pertinent as present social justice concerns and service user involvement in all aspects of care and education have gained ascendancy and impact on nursing practice.

2.3 The art of nursing

There is much discussion as to whether nursing can be identified as an art, as opposed to a science (Darbyshire, 1999). Johnson (1994) conducted a landmark study on the philosophical analysis of the nursing art by undertaking a comprehensive examination of forty one noted scholars' work. This concluded that the art of nursing comprised five separate senses. These included the nurses' ability to grasp meaning in patient encounters, establish a meaningful connection with the patient, skilfully perform nursing activities, rationally determine an appropriate course of nursing action, and morally conduct nursing practice. Finfgeld-Connett (2007) took this work a stage further by undertaking a qualitative synthesis of publications that related to the art of nursing. This involved fifty nine documents, applying content analysis and synthesis of the data using Strauss and Corbin's (1998) qualitative data analysis strategies. Finfgeld-Connett (2008b) found that the art of nursing is grounded in two types of knowledge: empirical and metaphysical. Empirical knowledge arises from research methodologies and underpins the art of nursing; one is essential to the other. Metaphysical knowledge relates to insights that are gained from unique experiences and has an element of intuition (Murray, 1994). Artful nursing also includes values and a commitment to holism (Ryan, 2004) Patients are treated with respect (Johnson, 1994; Loewenstein, 2003) and are empowered to make their own decisions (Loewenstein, 2003). One of the core attributes of the art of nursing is being relationship-centred (Lindeman, 1999); that

is, supported by metaphysical knowledge of self and others (Finfgeld-Connett, 2008a). A further key attribute of the art of nursing is expert practice which is developed from formal education and time and experience that are used to apply knowledge and to perfect technique (Gramling, 2004).

Congruencies do exist between Johnson's (1994) work and findings from Finfgeld-Connett's study on the attributes of artful nursing (Finfgeld-Connett, 2007). These similarities include grasping the meaning in patient encounters (Johnson, 1994) and the use of metaphysical knowledge (Finfgeld-Connett, 2007), as well as morally conducting nursing practice (Johnson, 1994) and practice based on values (Finfgeld-Connett, 2006). There are also similarities between Finfgeld-Connett's study and Carper's (1978) fundamental ways of knowing in nursing. As with Johnson's work, morally conducting one's practice can be linked to Carper's ethical way of knowing as well as applying values based care (Finfgeld-Connett, 2006). The findings of metaphysical knowledge appear to have overlaps with Carper's aesthetic and personal patterns of knowing.

2.4 Rituals and routines

Over the past twenty years there has been a move toward a more scientific, rational, evidence based underpinning to healthcare, which has been at the expense of the so called rituals and myths identified by Walsh and Ford (2001); there remains a pejorative view of rituals in nursing as actions or tasks that are routinised and have no underpinning theoretical basis (P. Ford & Walsh, 1994; Hatton-Smith, 1994; F. Strange, 2001a). Walsh and Ford (2001) argue that there is an element of lack of individualised thinking, doing things the way that they have always been done (S Philpin, 2006). Some ritualistic practices are seen as detrimental to the patient (Walsh & Ford, 1994) and the professionalism of nursing (Silberger, 1998; Walsh & Ford, 2001). Examples of rituals detrimental to the patient are excessive fasting before going to theatre, the routinised recording of observations such as blood pressure, even when the patient is due to be discharged, and some wound care practices (Skewes, 1996). Reading the wider literature reveals fundamental differences between the nursing literature on rituals

and that of other disciplines (S. M. Philpin, 2002), and there are differences even within the nursing literature. The 'nursing academic' journals tend to take an anthropological approach and are sympathetic to some of the functions of rituals (Chapman, 1983; C. K. Holland, 1993; Wolf, 1988), in contrast to the 'professional journal' genre which comes from a dismissive and negative viewpoint (S. M. Philpin, 2002); rituals in this instance are associated with poor practice and this does reflect a commonly held view of rituals in nursing (F. Strange, 2001a)

Putting aside the premise that some rituals in nursing can be equated with poor practice, this section of the chapter will examine the role of rituals in nursing, within which three clear themes arise. These are reducing anxiety and distress; responding to death and dying; and promoting values within the society of nursing. Much of the research that has been directly undertaken on rituals in nursing has taken an anthropological approach and uses an ethnographic framework.

One of the most frequent themes that arose from the literature on nursing rituals is their use as mechanisms for reducing the anxiety inherent in nursing, and how they serve to distance the nurse from the patient (Lee, 2001; Menzies, 1960; S. Philpin, 2007). Menzies (1960) presented a classic research study on stress and anxiety amongst nurses. She studied the nursing service in a London teaching hospital. She found that student nurses exhibited a high level of tension, distress and anxiety, and this she put down to the nature of the work and the feelings associated with it. She discussed the use of a rigid social defence system to alleviate these anxieties within the role of the nurse. This is manifested by the routinised performance of nursing tasks, which are carried out in an inflexible manner and based around self-protection. Chapman (1983) argued that this seriously compromised the nurse's ability to work flexibly and made every task a life or death procedure. Menzies' work was not directly aimed at exploring rituals, and only one reference was made to them in the text (Menzies, 1960, p. 103). Despite this she is credited as being one of the first researchers into nursing rituals.

Menzies' work was undertaken over thirty years ago and using the Human Relations School of Understanding Work Practices model which takes a psychoanalytic

approach to the study of human behaviour in organisations. The study ignored other possible influences such as other disciplines, social values, norms and expectations of the nursing role (Chapman, 1983).

A later study by Walker (1967) also examined nurses' behaviour within an organisational context and concludes that rituals which she assumes to be task-orientated behaviours have 'special significance to the actor rather than orientation towards organisation goals' (V. Walker, 1967, p. 7). Schmahl (1964) was in agreement with the idea that rituals develop in order to alleviate anxiety as the familiar is reassuring and can become routine. She suggests that:

> 'When we lose sight of the goal for which a routine has been established and are concerned instead with the form of the routine, we are involved in carrying out a ritual. A routine can be identified as a ritual when a particular form is being practiced in spite of changes in the situation that makes the routine no longer necessary and when the form is used to avoid facing the demands of new goals and developing increased awareness of new content and ways of dealing with it.' (Schmahl, 1964, p. 75)

Philpin (2007) undertook research on the role of rituals in the managing of ambiguity and danger in the intensive therapy unit. She found that they were essential to maintain social order within an environment that was extremely ambiguous. The ambiguity was caused by the nature of the work which involved looking at and handling body parts, and undertaking invasive procedures. Outside of the workplace these objects might engender strong emotions such as disgust, fear and fascination, whereas they would be commonplace within any intensive care unit. She suggests that these are rituals that serve a dual purpose of helping to diffuse emotions and encourage discontinuity from everyday life. They also have technical, rational and scientific elements that are essential to prevent infection.

Much of basic nursing care also involves breaching normal social boundaries which might cause anxiety and nurses have to learn how to deal with this (Stewart, 2005). Lawler (1991) in a study of student nurses giving their first blanket bath argued that ritualising care can reduce the anxiety caused by having to breach these social

taboos. The embarrassment can be defused by learning the rules or rituals for giving care. She suggests that the student nurses have to become skilful in negotiating social boundaries and creating appropriate contexts in which to avoid the potential embarrassment and shame experienced by them and patients (F Strange, 2001b); one example being touch, which is normally associated with intimacy and could be either sexual or caring. Strange (2001b) suggests that the wearing of a uniform and acting in an appropriate manner can signal that the intimacy is actually for caring and is therefore more acceptable.

A further example of the use of ritual to reduce stress and anxiety within nursing work was highlighted by Lee (2001) who explored the meaning of the ritual morning tea break to an unspecified number of nurses working in a medical ward in South Australia. From the research he suggested that this ritual had clear functions, in that it was used by the nurses as an opportunity to ventilate their feelings and issues about difficult situations that they encountered on the ward. They were reluctant to discuss their work with non-nursing friends or family, but used the tea break to gain support and regain their internal balance.

Focusing on the second identified theme, there is throughout the literature on nursing ritual a theme that relates to the fear of facing death and dealing with the death of others (Gerow, et al., 2010; Goopy, 2006). This brings with it the challenge of nurses having to face the inevitability of their own mortality when nursing a dying patient. Chapman (1983) undertook research over three five month periods of participant observation in five hospitals in South London. She identifies cultural patterns of avoidance that are at the root of the social rituals that take place before, during and after a patient dies. Chapman refers to them as concealment and avoidance rituals that were carried out when death occurred in the hospital. These are identified by Chapman as part of hospital life cycle rituals or *rites de passage*, and are reminiscent of Van Gennep's *rites de passage* or stages of social transition (Van Gennep, 1960). Helman (2007) identifies the stages that the dying person goes through as they move from their biological death to their social death, and the rituals that are associated with these stages.

These particular rituals in nursing appear to be acceptable when applied to providing spiritual care to dying patients and their families (Froggatt, 1997). The performance of last offices is generally viewed favourably. Wolf (1988, p. 62) suggests:

> 'Working as a group during post mortem care, nurses helped each other ease the realities of death. Their washing of the patient and the straightening of the hospital room represented, on a latent level[,] the purification of the patient and the room. Thus some of the soil and profanity of death was removed.'

Walsh and Ford (2001), however, disagree and are critical of the ritualistic, post mortem practices of washing the body and its concealment from other patients during its removal. Linking on from this is the fear of causing harm and death to others by the nature of what nurses do. 'It is the framework of potential death and the presence of this elementary fear that so many routines in hospital are instituted and performed so religiously' (Chapman, 1983, p. 16).

The third theme that relates to the role of rituals in nursing is the social meaning of nursing rituals. Rituals are a feature of all human societies or social groups and their function is to celebrate, maintain and renew the world in which they live (Helman, 2007). Nursing occurs in social groups, and there are rituals that serve to pass down their beliefs and values to novices coming into the culture (A. Smith & Stewart, 2011) (K. Holland, 1999; A. Smith & Stewart, 2011). Rituals serve to express symbolic meaning important to groups of people functioning within a culture or subculture (Wolf, 1988, p. 59). Examples of these are the shift handover (F. Strange, 1996) and wearing of uniform which is one of the unseen or covert cultural rules (C. K. Holland, 1993; Silberger, 1998). Silberger (1998) defines rituals as part of the culture of nursing and says they strengthen the profession. There are some practices that could be classed as ritual or science, and may have meanings that are opposite to each other: for example, the bath, which may give comfort to a patient but, has no underpinning research to support it.

In other studies, Wolf categorises nursing tasks into sacred and profane. Examples of the sacred are wound care, hand washing, and medicine dispensing; the profane include emptying bedpans and vomit bowls. She also found that there were underlying principles behind the nursing practice: one was the notion of doing good and avoiding harm; and the second was the sub cultural transfer of knowledge which was achieved by word of mouth and demonstration (Wolf, 1988).

Wolf (1988) undertook an ethnographic study of rituals in a medical unit of a large urban hospital in North America and identified three therapeutic nursing rituals: post mortem care, medication and bathing patients. She identified a plethora of values and beliefs about the promotion of hygiene in the prevention of disease which started in the 1800s and have become embedded into the art and craft of nursing. She was one of the first writers to ascribe positive comments on the nature and function of nursing rituals. She described the patients' bathing routine as a therapeutic nursing ritual which offered comfort and aided healing, and failing to keep patients clean or omitting a bath violated a nursing norm (Wolf, 1993, p. 144). The bathing ritual according to Wolf (1993) provides the nurse with ideal opportunities for patient observation and contact.

> 'Nurses heal when they wash patients, cure disease when they lay hands on during the bath, and purify patients symbolically when they perform this very personal care' (Wolf, 1993, p. 145).

Wolf also identified another occupational ritual the shift handover – which she viewed as the forum where nurses learn to understand the actual meaning of what it is to be a nurse (Wolf, 1989).

Pediani and Walsh (2000, p. 36) took the theory of rituals in nursing and translated it into 'the meme hypothesis' which is another example of rituals conveying social meaning (Dawkins, 1989). Memes are cultural replicators, unit imitators or uncritical attitudes or beliefs. Examples are books, spoken language and observation. They are the traditions and myths that are passed from generation to generation, or laterally from nurse to nurse, sometimes without any underpinning evidence. They may be equated with 'conversations of change' (J. Ford, Ford, &

McNamara, 2002). These memes can also be equated with nursing rituals. Traditional nurse training, pre-Project 2000, was based on an apprenticeship system where students were taught on the job and in a task orientated way. This provided an ideal environment for the evolution and replication of memes. Pediani suggests that these existing or 'resident memes' are stronger than the new 'evidence based memes', and are the frameworks for resistance to change. Examples of these resident memes include the belief that acute pain relief by the use of opioids will lead to addiction, and consequently nurses have historically under dosed patients (Cartwright, 1991). This work is not based on research, but is an extrapolation of the biological evolutionary principles identified by Gottlieb and Gottlieb (1998).

Investigation into rituals has identified that it is a complex phenomenon that has been viewed derogatively by a core of nursing theorists (P. Ford & Walsh, 1994; Hatton-Smith, 1994; Walsh & Ford, 1994). Research into the literature indicates that rituals are nonetheless still prevalent in nursing, for the reduction of anxiety caused by the nature of nursing work. They are linked to self protection, as a 'just in case' scenario, and as an effort to come to terms with nurses' own mortality. Much of the above literature omits to take into account the wider functions of rituals, which are those that relate to nurses as a cultural group. Some authors take exception to the idea that outdated poor practice is labelled as ritual (Silberger, 1998).

2.5 Change

Nursing takes place in a complex context that is subject to constant change and reform. This change is implemented both locally and nationally. These reforms are generally led from central government and have modernised all aspects of nurses' roles, including terms and conditions of employment, and competencies within roles which have become linked to the planning of personal and career development (Department of Health, 2000, 2004a). This section will address the nature of change, changing practice or practice development, and individuals' response to change and resistance to change.

2.5.1 Change and nursing care

At a micro level the very nature of nursing is the caring that leads the recipients of that care to change in order to get well, live more effectively with their illness or have a dignified death. Nursing, therefore, could be defined as 'the activity of bringing about change' (Hussey, 2002, p. 104). Writers who take a naturalistic ethnographic approach view change as an inevitable process for any individual (Defeo, 1990; Stephenson, 1987). This change is viewed as a biological process arising because of the notion that all life is in a state of flux: in human beings this relates to birth, development, ageing and death. As nurses provide care within this context, change has to become an integral part of the care (Copnell, 1998). This has led some authors to suggest that nurses should view change as an inevitable part of the role, a normal life event (Stephenson, 1987; Tiffany & Lutjens, 1998) linked to growth and development (Defeo, 1990).

One of the most influential writers on change in nursing is Wright (1998). Change according to Wright is a process that results in the alteration or replacement of knowledge, skills, attitudes and styles of individuals or groups. Change can involve the discontinuation of past behaviours, and the resulting perceptions, feelings and emotions that arise as a result of the change. Change includes both the process and the outcome. This definition addresses the change directly to the individual, and has the elements of consistency and difference as applied to the before and after.

When exploring writers' work on change and nursing, it is clear that many assumptions are made. These include the fact that change is desirable, as it is inevitable. Another assumption is that change can be a managed process; the subject 'managing change' is a dominant theme in management and nursing literature (Broome, 1998; Copnell, 1998; Wright, 1998). A further assumption in the literature is that managing change involves a series of specific stages that can be influenced, very often by a change agent. The literature cites strategies and theories that are generally not context specific or linked to any particular historical time. Broome (1998), for example, cites change theories and strategies that were written as a result of research on a wide range of organisations, yet it is suggested

that they could be applied to multiple changes in nursing. A further example is Lewin's model of force field analysis that was devised in 1951 in the USA following research on housewives. This model is cited extensively in the literature that relates to the management of change in nursing and healthcare. It is the writer's experience that Lewin's model is also used widely when teaching change in nursing, without reference to the context or historical background.

Another assumption is that change is logical and rational, and is more effective when it is a planned activity that follows a clear strategy identified before the change is implemented (Broome 1998). These change strategies often involve a change agent or agents whose role it is to implement the change. Some of the strategies identify clear stages that people go through in order to change (Lewin, 1951). Others discuss the strategies that the change agent might adopt to implement the change (Bennis, Benne, Chin, & Correy, 1976). Other change strategies involve a bottom up approach, where those involved in the change effect the change with support from managers (Ottaway, 1976). Much of the available research focuses on how individuals respond to major organisational change, and was undertaken on private sector employees during processes such as mergers and acquisitions, restructuring, and the introduction of new structures and working practices (Morrison & Milliken, 2000), yet is still applied to multiple examples of change in healthcare organisations.

There seem to be two conflicting perspectives to change in the literature. One is that change is a natural part of life, inevitable and will take place even if nothing is done to influence it. The second is that change is more effective if it is managed with a clear strategy and by identified individuals within the organisation (Bridges, 2002; Brisson-Banks, 2010).

There is however one theory that makes the assumption that change can occur without active management. This is Rogers' Innovation Diffusion Theory (E. Rogers, 1983b). Rogers' work was based on early research into how farmers adopted innovations, along with a literature review of existing studies. The work researched how innovations diffuse or spread within a social system, and identified a series of

categories which individuals fell into according to how they responded to the implementation of innovation. These categories were innovators; early adopters; early majority; late majority; laggards; and rejecters. His work is now widely accepted in communication and technology adoption studies. This theory has its critics, including Hageman and Tiffany (1994, p. 60) who describe it as 'change watching' rather than 'change planning'.

2.5.2 Practice development

One clear field of study that addresses how practice changes is practice development. Much of the literature views practice development as a process for managing change in nursing practice and is linked to a practice development role (Manley & McCormack, 2003; McCormack & Garbett, 2003). Practice development is a recognised and growing movement in nursing, and has been defined as the 'interconnected and synergistic relationship between the development of knowledge and skills, enablement strategies, facilitation and a systematic, rigorous and continuous process of emancipator change in order to achieve the ultimate purpose of evidence-based practice person-centred care' (McCormack, Manley, & Garbett, 2004, p. 29). The concept has been associated with development of healthcare practices and nursing development (Manley, McCormack, & Wilson, 2008a). The role of practice developer has been established in some healthcare organisations in order to promote practice development.

Practice development can be found in other disciplines as well as nursing. In social work the term practice development has been used in relation to improving aspects of work such as the production of social enquiry reports in line with national guidance and recommendations (Bottoms & Stelman, 1988), which suggests that practice development may be brought about in response to national frameworks and guidance. Both in medicine and accountancy this theme continues, with practice development being used to describe the implementation of new work systems or services which are designed to improve the business (Unsworth, 2000). In counselling, however, it is viewed as the process of examining and improving certain key areas of work (Dryden & Feltham, 1994). The focus of practice

development in all of these disciplines includes the notions of improvement, the meeting of unmet needs, and effectiveness (Unsworth, 2000).

Practice development can be both a process and an outcome of nursing practice. The process, which dominates the literature on this subject, involves developing frameworks to enable practitioners to look critically at their practice with a view to improvement. Key concepts related to practice development include workplace culture, person-centredness, facilitation; practice context; and evidence, values and approaches to active learning (McCormack, et al., 2009; McCormack & Garbett, 2003; McCormack & McCance, 2006).

The outcomes of practice learning have been articulated as one of the principles of practice development activities: person-centred and evidence based care that is manifested through human flourishing and workplace culture of effectiveness in all healthcare settings and situations (McCormack, et al., 2009, p. 94).

The process that practitioners engage in during practice development has been identified as active learning (C L Clarke & Wilson, 2008; McCormack, et al., 2009). This involves the process of learning through reflection on current nursing practice. Dewing (2008) suggests that this learning involves engaging with all of the senses, critical reflection and self-awareness.

This thesis is investigating how practice changes and develops from the nurses' perspective, and consequently there are overlaps between this body of knowledge and the subject matter under investigation. This concept will be further developed in the study findings and final discussion of the theory.

2.5.3 Individual responses to change

Many of the theories on the human resource aspects of change identify it as a transition, a process that is internal to the individual, and is the shift or movement from the before to the after (Armstrong, 2006; Bridges, 2002). Transition is generally thought of as part of the change process. This process might assume a linear progression, where the individual moves from one stage to another in a set order, and every stage is dependent on the previous one (Burnes, 2003). Other perspectives on transitions are that individual responses to change are recurring, interdependent and discontinuous (Nicholson & West, 1988). Some work suggests that the individual change transition may

be seen as indecisiveness where individuals oscillate backwards and forwards during the process (Woodward, Bucholz, & Hess, 1987). Other models suggest that the change transition may be cyclical (French & Delahaye, 1996a).

An individual's response to change is generally identified in the literature as a series of stages that the individual might go through. Appendix 1 identifies a range of transition models, the underpinning source, and comments on the categorisation of the model.

There are commonalities across all of the models. The first stage is identified as the feeling of security that exists before the transition occurs. These are the familiar processes, habits and patterns that have taken place and proved successful (French & Delahaye, 1996b); another interpretation might be the socially constructed realities that involves shared meanings, shared understanding and shared sense making that individuals develop to guide their behaviour (Morgan, 1986). Examples of these socially constructed realities include the everyday processes that individuals undertake, which for nurses might be the handovers at the end of shifts and the nursing models that are used to plan care.

Some of the work on how individuals respond to change identifies a process of loss, (Bridges, 2009; Curtis & White, 2002; Eriksson, 2004). This may include one or several of the following: loss of power or influence (Arden, 1999), loss of

professional identity, expertise or competency; loss of status and social relationships; and loss of control and familiarity (Salmond, 1998). Some authors draw comparison to the classic work on the grief cycle (Kubler-Ross, 1969). Perlman and Takacs (1990), for example, have developed a comprehensive grief-change framework which is made up of ten stages that the individual experiences as they come to terms with the change. This framework adds five extra stages to the grieving process originally identified by Kubler-Ross: equilibrium, chaos, resignation, openness, and readiness and re-emergence. Anxiety is the response to the loss of the familiarity of old patterns and processes (French & Delahaye, 1996a). Other responses included 'Heads down, alienation, isolation and loss, unbalanced, and the individual is in a state of 'disequilibria" (Knight, 1998, p. 1291); and loss of control and a feeling of loss of competence (Perlman & Takacs, 1990; Schoolfield & Orduna, 1994). Other authors discuss denial that might present as apathy and numbness (Curtis & White, 2002; Rachford & Coghlan, 1994; Scott & Jaffe, 1989). This is reminiscent of the first stage of the grieving process. Other grief related feelings include bargaining and chaos (Perlman & Takacs, 1990).

Carnall (2007) identifies the process of coming to terms with change as a coping cycle of which the first stage is denial, and the individual undergoes a kind of immobilisation or a sense of being overwhelmed. Although this is one of the stages identified above and in the grief cycle, there are few similarities between Carnall's stages and those of the grief cycle. Defence is the second stage and this is where reality starts to hit. Obstacles are put in the way of the change, previous ways of being are glorified, and defensive behaviour leads to hanging on to old ways of doing things. The third stage is discarding and is similar to discovery when new information, skills and behaviour are uncovered (French & Delahaye, 1996b); it is about empowerment and rise in self-esteem. Part of this phase is about letting go of the past. Scott & Jaffe (1989) identify this stage as exploration. In the exploration phase there is an element of chaos as individuals work out new interpersonal relationships, and get to grips with new systems and processes. There is a lot of uncertainty and it may lead to stress.

The final stage is integration (French & Delahaye, 1996b) or adaptation (Carnall, 2007). This stage is the action phase of the change transition. This is where new information, skills and behaviours are employed and evaluated, and a commitment is formed that binds the new behaviours together.

2.5.4 Resistance to change

Individuals, as previously discussed within this chapter, do naturally respond to change. Response to change that is perceived as detrimental to the outcome of that change is known as resistance to change (Bovey & Hede, 2001a; Waddell & Amrik, 1998). Much of the literature on resistance to change centres on implementing organisational change and individual responses to these changes (Pardo de Val & Fuentes, 2003). Resistance to change tends to be portrayed in the literature as 'an unwarranted and detrimental response residing completely over there, in them (the change recipients) and as a response arising spontaneously as a reaction to change, independent of the interactions and relationships between the change agents and recipients' (J. Ford, Ford, & D'Amelio, 2008, p. 362). Despite this one sided view of resistance, research has shown that resistance to change can be beneficial and have a positive impact on decision making in organisations (Nemeth, Brwon, & Rogers, 2001).

This resistance can be viewed from several perspectives including a mechanistic approach , social view and a conversational construction between the change agent and the recipient of that change (J. Ford & Ford, 2009).

The mechanistic view, borrowed from the field of mechanics, views resistance as a force for change, pushing against the current situation which acts as a restraining force. Lewin's work on his Force Field Analysis is an example of a mechanistic view of resistance to change (Lewin, 1951). Within the mechanistic perspective, resistance can be viewed as neutral, in that it is neither good nor bad, beneficial nor detrimental, and is a product of interaction between two forces – change agents and change recipients – and any change agendas (J. Ford & Ford, 2009).

Although resistance to change is often viewed as exceptional, from a mechanistic perspective it is actually a natural phenomenon evident in individuals' everyday

behaviours within the workplace, and can serve as a means of slowing down organisational progress (Gergen, 1994). These individuals' behaviours become part of the organisational practices and discourses, and examples of such behaviours include being late, missing meetings, failing to perform, and bullying and harassment. These behaviours are 'worked around' on a daily basis, so that their impact on the organisation is minimised (J. Ford & Ford, 2009).

The social view of change, which takes a human relations perspective, takes the stance that resistance is exceptional, characterised by new behaviour that only happens in response to change, is detrimental to progress, and is a product of individuals and groups rather than their interactions (Dent & Goldberg, 1999; J. Ford & Ford, 2009; Sudi & Michael, 2009). Implicit within this view is that all organisational changes are beneficial, and the role of the change agent is to align the organisation within the environment in order to improve productivity and performance. This view is in direct opposition to the mechanistic view of resistance to change.

The development of this approach is credited to Mayo and came about as a result of the research undertaken on the Western Electric Company (Nord & Jermier, 1994). Resistance to change is seen as the workers' personal property and is located 'over there, in them' (J. Ford, et al., 2008, p. 219). This approach was also taken in the landmark study of Coch and French in 1948 on research with factory workers (I. Smith, 2005). The fundamental challenge with both of these studies, and the reason that they are criticised within the literature, is that they focused their explanations for resistance on the personal and group characteristics of the workers and knowingly ignored all other influences such as management and management practices and communication across the organisation (J. Ford & Ford, 2009). A further challenge with the social view of change is that resistance is seen as detrimental to the success of the change. Other research however has found that resistance to change can be beneficial (Nemeth, et al., 2001).

The social view of change suggests that resistance is played out in the form of exceptional behaviour, is not an everyday occurrence and something that only

happens in response to change (J. Ford & Ford, 2009). Drazin and Joyce (1979) suggest that within the social view of resistance to change there are three manifestations: inactive, misdirected and oppositional. Inactive and misdirected forms result from existing and habitual behaviours in the workplace, whereas oppositional resistance is something exceptional or different behaviour. There is no further research available on what proportion of resistance to organisational change falls into these three categories, or how ordinary resistance differs from exceptional resistance.

The postmodern constructivist perspective, however, suggests that there is no one objective reality in life that can be applied to all individuals. Reality is interpreted, constructed or enacted through social interactions (Berger & Luckmann, 1966), and these constructions contribute to the context within which individuals operate (J. Ford, et al., 2002). This constructed reality within organisations is played out through a series of conversations or discourses that constitute these realities (Dent & Goldberg, 1999; J. Ford, et al., 2002). These conversations can take the form of what is said or listened to between people within the organisation (Berger & Luckmann, 1966), and can be auditory, visual, and tactile events as well as the symbols and artefacts that exist within the workplace (J. Ford, et al., 2002). Conversations provide the context and processes through which activities are achieved within organisations and are both the process and product through which reality is constructed (Berquist, 1993).

Background conversations of change have been identified as the 'implicit, unspoken backdrop or background against which explicit foreground conversations occur' (J. Ford, et al., 2002, p. 105). These background conversations are a result of the culture, history or sets of attitudes that bind individuals in an organisation together. The individuals through the background conversation gain identity and support, and it offers a means to tie the group together (Berger & Luckmann, 1966; J. Ford, et al., 2002). Hence the reality of organisational life is one of communities with sets of background conversations and different rules, moves and conversations for individuals to follow. The communities have common agreements, conventions, and rules that reinforce the background conversations, leading to the maintenance

and regeneration of the communities within the organisation (Winograd & Flores, 1987).

Resistance therefore is a function of the constructed reality within the context that the individual lives or works in (J. Ford, et al., 2002). Ford, Ford and McNamara (2002) apply this theory to resistance to change as being within networks of conversations as opposed to within the individual. They argue that the links between similar conversations add increased attraction to keep the subject of that conversation in place, hence maintaining stability, and so any move to alter this will be met with resistance (M. Moon, 2008). Differing background conversations mean that two or more contexts or ways of viewing the world have to interact and one result of this kind of situation leads to resistance.

Ford, et al, (2002) suggest that during organisational change there are differing types of background conversations or realities that colour and characterise the change. These backgrounds are complacency, resignation and cynicism, and the conversations centre on successes and failures. The complacent background is built upon historical success, and the background conversations relate to 'what we have done has worked previously so there is no need for change'; clichés such as 'why mess with success?', 'if it is not broken, don't fix it' and 'don't rock the boat' are the themes of common resistant conversations of change (J. Ford, et al., 2002, p. 110).

The second background conversation is entitled resigned and is a product of perceived historical failure rather than success. The conversations in this instance originate from individuals blaming both themselves and the organisation for failure, and examples include 'my position doesn't give me any power' and 'I don't have the skills background or luck'. When referring to the organisation within this conversation individuals might say 'we never get the support we need' or 'our group never gets included in the big decisions' (J. Ford, et al., 2002, p. 109).

The third background is cynical, which like the resigned background is derived from historical failure, either directly or vicariously experienced by others within the organisation. In this instance, however, the cause of failure is attributed to a

perceived external reality and to other people and groups. Statements such as 'who are they kidding, no-one can make this work' and 'I don't know why they bother, this won't work either' illustrate a cynical background (J. Ford, et al., 2002, p. 209). Individuals within this organisation take a pessimistic view in which failure is expected and is due to shortcomings in others in the organisation, and to external factors outside their control (Reichers, Wanous, & Austin, 1997).

This approach suggests that these backgrounds lead individuals to have differing conversations, actions and behaviours in response to change, and accordingly there are differing resistive conversations. The complacent background conversations construct a reality in which there is a complacent denial of the need for change, leading to procrastination, avoidance and withdrawal. The resigned background produces behaviour that includes lack of attention to the proposed change which ultimately leads to reduced morale, non-participation and other forms of covert resistance (J. Ford & Ford, 2009). The third background conversations lead to a cynical approach in which individuals are confident that the change will fail and no matter what anyone does, either within the organisation or externally, success will not happen. The attitudes elicited include anger, scorn, derision and contempt (Stivers, 1994).

2.6 Changing practice to become more research orientated

There has been an emphasis nationally since the 1990s on the importance of incorporating research findings and evidence based care into clinical practice. This emphasis was first highlighted in the White Paper 'The New NHS, Modern and Dependable' (Department of Health, 1997) where the concept of quality was identified as the combination of good clinical care with cost effective treatment (Nolan, et al., 1998). The use of best available evidence or best practice is also cited by the present government's health agenda (Department of Health, 2010a). Nursing, however, is still seen as wedded to the medical model with the positivist, scientific view point valued highly, and care is dominated by illness as a starting point as opposed to the intangible and invisible components of the humanistic aspects of nursing roles (Antrobus, 1997; Fulbrook, 2003).

Research utilisation, which is part of the evidence based practice agenda, is identified in the literature as the use of research or evidence to guide practice (S Mantzoukas, 2007; Traynor, Boland, & Buus, 2010). This is a complex social process that is influenced by the characteristics of the health professional using it and the context within which it is set (Traynor, et al., 2010). A significant desired change in nursing practice nationally is for individuals to incorporate more evidence into their everyday practice (McSherry, Artley, & Holloran, 2006; Paramonczyk, 2005). The final section of the literature review will explore barriers that nurses perceive hinder their use of research in practice.

2.6.1 Barriers to research utilisation

This section will review what the research literature states about the barriers that nurses perceive stop them utilising research in their everyday practice.

The Barriers and Facilitators to using Research in Practice (the Barriers Scale) was developed by Funk, Champagne, Wiese and Tornquist (1991a) in the United States. This scale was based on a literature review and is underpinned by Rogers' Theory of Diffusion and Innovation (E. Rogers, 1983b). It consists of twenty eight items that are divided into four sub-scales: characteristics of the adopter (nurses in this case, and their values, skills and awareness); characteristics of the organisation (the setting); characteristics of the research (qualities of the research); and characteristics of the communication, presentation and accessibility of the research. These characteristics reflect the four main elements in the diffusion process identified by Rogers (1994). This Barriers Scale has been used extensively to investigate a range of professionals' responses to research utilisation in their practice.

There is lack of agreement with regards to the validity of the Barriers Scale. Some authors report the scale as having high face and content validity (Funk, Champagne, Wiese, & Tornquist, 1991b; Kajermo, Nordstrom, Krusebrant, & Bjovell, 1998; S. L. Lewis, Prowant, Cooper, & Bonner, 1998b; Kader Parahoo, 2000). However, others cast doubt on the validity of the scale as a robust international representation of barriers to research utilisation due to lack of internal consistency for some factors

(McCleary & Brown, 2003; Retsas & Nolan, 2000). It could, however, have a value in assessing components that are unique to a particular practice setting and provide a useful diagnostic tool for those involved in practice development (Dunn, Chrichten, Row, Seers, & Williams, 1998).

The scale has been used in research in several countries: United States (Funk, et al., 1991a), Great Britain (Carrion, Woods, & Norman, 2004), Australia (Retsas, 2000), Sweden (Kajermo, et al., 1998) and Turkey (Kocaman, et al., 2010).

The main barriers to nurses' lack of research utilisation in practice cited in the literature using this scale relate to lack of time, skill, resources, and authority. Hutchinson and Johnston (2006) reviewed 35 studies published between 1991 and 2001, all using the Barriers Scale as devised by Funk, et al (Funk, et al., 1991b). The three most commonly cited barriers related to lack of time: insufficient time to implement new ideas, and lack of time to read research resulting in a lack of awareness of research findings (Alison M. Hutchinson & Johnston, 2006). As well as lack of time, insufficient skill, resources, and authority are consistently cited in the literature from the United States, Canada, Europe, and Australia as major barriers to research use (A. M. Hutchinson & Johnston, 2004; McCleary & Brown, 2003; Oranta, Routasalo, & Hupli, 2002; Retsas & Nolan, 2000).

Further research identified the organisation and the setting in which practice takes place also to be of significance in nurses' reluctance to use research in practice. Glacken and Chaney (2004) identified eight barriers related to the setting in which practice takes place. These findings were supported by other researchers and included insufficient support from administrators; the belief that nurses lacked authority to change practice, and that management wouldn't allow implementation of new research; insufficient knowledge of research and statistical analysis; and inadequate available research for nursing practice (Bryar, et al., 2003; Micevski, Sarkissian, Byrne, & Smirnis, 2004; Winch, et al., 2005).

The challenges within these studies are the lack of qualitative data gathered to complement the findings. All of them identify the barriers to research utilisation but there is minimal discussion beyond this. All studies quoted discuss the issue of the

number of participants that identify no opinion on the scale; several of the studies reported no opinion responses of greater than 25% for the category that related to the quality of research or research reporting (Dunn, et al., 1998; McCleary & Brown, 2003). This may have had an influence on the ranking of other barriers. The Barriers Scale was developed and tested on a stratified random sample of 1,989 members of the American Nursing Association, with a low response rate of 40% (Funk, et al., 1991b), and in general the studies using the Barriers Scale reported a low response rate; Parahoo (2000) reported 52.6%, and Lewis, Prowant, Cooper and Bonner (1998a) reported 34%.

The majority of the studies acknowledge limitations in the size and type of sample used; for example, convenience samples were predominant (Dunn, et al., 1998; S. L. Lewis, et al., 1998b; Kader Parahoo, 2000).

2.7 Summary

This literature review has explored a range of literature that pertains to the subject of practice change and development. The fields included an overview of nursing knowledge and nursing as an artful practice, the role of rituals in practice and an overview of change. This overview looked at how change in healthcare has been reflected and individual responses to change, as well as the nature of practice development. Resistance to change in the organisation, and barriers that nurses perceive as preventing them from utilising research in their practice, were explored in the final sections of the review.

CHAPTER 3

DEVELOPMENT OF THE RESEARCH QUESTIONS

3.0 Introduction to the aims of the study

The researcher of this study has been a nurse and educationalist for thirty eight years. There has always been an unwritten assumption in nurse education that one of the aims of post qualifying nurse education is to facilitate students to gain the knowledge and tools in order to effectively improve their practice, the underlying premise of education therefore, was to influence practice change. To this end the aims of this study are to investigate how practicing nurses perceive that their care changes over time, which aspects are the most significant to them and if there is an identifiable process to this change. The research will also investigate factors that promote and cause resistance to change at both organisational and personal levels. The aim is to produce recommendation to inform effective change management for the future.

Health service management, professional development and change management were specialities that the researcher taught for many years and this informed the interest of the subject and development of the research questions for this thesis.

Both these unwritten assumptions and the researcher's interest contributed to the identification of the aims and research questions of this study.

3.1 Context within which the study was undertaken

Healthcare and nursing have been subject to political intervention since the inception of the NHS in 1948 (Bradshaw, 1995). These interventions have extended to significant aspects of nursing including the role, quality of care, career pathways and terms and conditions of service. Two consecutive Prime Ministers have recently commented on the 'what to do about nursing' question (MacCullum, 2012, p. 137). The current Prime Minister set out five priorities for nursing to reduce bureaucracy in order to focus on the quality of care given (MacCullum, 2012). These priorities included reducing paperwork, regular nursing rounds focusing on comfort, feeding

and hydration, improving leadership on the wards, including patients in quality inspections and seeking feedback on the quality of nursing care from friends and family. This section of the chapter will look at the context within which nursing practice takes place and some of the political drivers that have impacted on changes over time.

Changes imposed by the previous Labour governments (Blair, 1994-2007; Brown, 2007-2010) have impacted on all aspects of nursing including terms and conditions, levels of accountability, role and nature of the work, underpinning knowledge and expectations in the form of evidence based practice and extended responsibilities, along with a focus upon continual change as part of the ongoing quality assurance agendas. The whole context within which professional practice takes place has been shifting towards increasing patient power in terms of knowledge, expectations and choice, and some would suggest also eroding professional power and autonomy in the process. The focus of the current Coalition government is on continuing with the previous governments' reforms, shifting health into the community which in turn will impact on the role of the nurse. Thus nursing takes place within a context of continual change both at a personal, local and national levels, and this will be the norm for the foreseeable future.

In the last decade one of the main drivers for change has been the 'NHS Plan' (Department of Health, 2000). This White Paper (Department of Health, 2000, p. 104) focused on two main reforms: 'getting the basics right' and 'improving the patient experience'. This has meant modernisation of all terms and conditions for non-medical staff, including nurses. One of the key areas of modernisation defined and described the knowledge and skills which NHS staff needs to apply in their work in order to deliver quality services. The Knowledge and Skills Framework (KSF) provided a single, consistent, comprehensive and explicit framework in the form of competencies which are linked to roles (Department of Health, 2004b). These are now embedded into personal development planning and significantly contribute to career progression across the Health Service.

Over the past decade nursing and the role of the nurse in practice have also been subject to major change, again driven by further government agendas. The world of nursing is changing rapidly, patient and user expectations are increasing, and health reforms are altering professional roles and how services are delivered (Department of Health, 2006, p. 5).

The changes driven by output orientated government initiatives include benchmarking projects and best practice guidelines which comment directly on how nurses should practice. One example directed at Directors of Nursing is Confidence in Caring: A Framework for Best Practice (Department of Health, 2008) that directs nurses towards five confidence creators, core issues that will improve caring. These confidence creators actually prescribe hands on care directed towards aspects of caring such as managing a calm, clean environment and patient communication.

There has been an on-going programme of modernisation of the role of the nurse since the early 1990s, which was further reinforced by the Working Time Directive that reduced doctors' hours and led to a proliferation of nurse practitioner roles (Herbertson, Blundell, & Bowman, 2007). This 'modernisation' of the NHS has led to major changes in the responsibilities, accountabilities, autonomy and skills of nurses as previous barriers between the roles of nurses, doctors and other health workers were relaxed. Nurses now routinely work to an advanced practice level working autonomously across a range of specialties (McGee & Castledine, 2003).

More recently the Modernising Nursing Careers initiative (Department of Health, 2010c), which has aimed to coordinate these developing roles into a national career structure, is near completion. It commenced in 2006 and has now culminated in a national careers frameworks poster which identifies how nurses can progress both up and through specialties, along with the continuous professional and personal development needed to succeed. This framework is similar to a skills escalator, providing examples of career structures in the form of career pathways for nurses to follow in order to guide their future developments.

There is also on-going pressure on nurses to standardise and improve their hands on care to patients. Essence of Care is a benchmarking exercise which commenced in 2001 and was focused upon improving quality in fundamental aspects of care and the patient experience, establishing a set of standards that NHS organisations can use to audit nursing care (Department of Health, 2010b). This has recently been updated and the benchmarking process outlined in Essence of Care 2010 supports practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice (Department of Health, 2010b).

Both the Labour government under Brown (2007-2010) and the present Coalition government are in agreement that the role of the nurse has to change and develop in order to address current and developing health agendas (The Prime Ministers Commission, 2010; UK Professional Leadership CNO's Directorate, 2011). These agendas include an increase in the number of patients with long-term conditions, care being delivered closer to home with an emphasis on self-care. The on-going emphasis in healthcare to encompass the ever increasing public health agenda has led to the necessity for a change of focus in role and the development of new skills for nurses across all specialities. This agenda continues and promises to be strengthened within the current government reforms of the NHS (Department of Health, 2010a).

The second reform within the NHS Plan and a theme that has been ongoing within current government reforms is increasing patient choice (Dealey, 2005; Department of Health, 2004c, 2010a). Systems and processes are being developed that will facilitate patients to be more involved in decisions about their treatment and care. The NHS will be more focused on results that are meaningful to patients by measuring outcomes such as how successful their treatment was and their quality of life, not just targets such as waiting lists (Department of Health, 2010a).

It can be seen therefore that the context within which nurses' function are constantly being changed and reformed at both national and local levels. These reforms have modernised all aspects of their roles including terms and conditions

and competencies within roles, are linked to personal development planning and career progression, and require them to continually update and change how they practise. It is within this context that this study is situated, and in which the research participants function on a day to day basis and practise their hands on care.

3.2 Impact of the literature review on the development of the research questions

The literature review explored aspects of nursing practice that could change, change and resistance to change in terms of the individual resistance to using research in practice and resistance and individual responses to change.

Artful or aesthetic nursing has been explored within this literature review as it is a fundamental basis of all nursing practice and to provide artful nursing is a desirable attribute (Averill & Clements, 2007; Chin & Kramer, 2004). The literature review has also identified that nursing practice is underpinned by several sources of knowledge and it is reasonable to suggest that any change in practice is going to lead to a change in underpinning knowledge that may contribute towards the development of artful nursing. Changes in nursing practice, according to the literature appears to be based upon a change or development in proximal knowledge (Trinder, 2000). Different researchers have identified similar types of nursing knowledge within this proximal knowledge, each allocating a slightly different name (Bonis, 2009; Easterbrooks, et al., 2005; S. Mantzoukas & Jasper, 2008). How knowledge changes as practice changes and develops has also been ascribed to the process of reflection which focuses on experiences gained in practice (Gilbert, 2001; Heath, 1998; Johns, 2009).

As identified previously the literature review highlights that the underpinning knowledge of nursing practice changes over time. However what is not clear are any other aspects that might also change, the relationship between them, and which type of change presents as the most significant for nurses which is one of the aims of the study. The following research question was therefore developed to address this aspect:

How do nurses understand practice change and development, and how can it be described?

The literature on change in nursing focuses on the implementation of organisational change and devising the most effective strategies for this implementation. An individual's responses to these types of changes are generally identified in the literature as a series of stages that the individual might go through. Appendix 1 identifies a range of transition models, the underpinning source, and comments on the categorisation of the model. None of this literature relates directly to change in nursing practice which is the subject of this thesis. The research will investigate if there is an identifiable process for change in practice and how comparable this is to the identified individual responses to change. The following research question was developed to address this issue:

What is the process that the nurse undergoes as their practice changes and develops over time?

Resistance to change in the literature focuses on response to changes that are imposed and is seen as something that needs to be resolved as it can be negative to the outcome of that change (Copnall, 1998). There is limited literature, however on the manifestation of resistance to change in clinical practice which is the subject of this thesis (Copnell, 1998; Copnell & Brunei, 2006).

Research into the literature on nursing rituals indicates that rituals are still prevalent in nursing (S Philpin, 2006) where they serve a range of functions. These functions include reduction of anxiety caused by the nature of nursing work, as a means to come to terms with nurses' own mortality and promoting the cultural values of nursing (Lee, 2001; Gerow,et al., 2010; Smith & Stewart, 2011). The areas where there is a lack of available literature are the role of rituals in practice change and as a means of resisting change and this is the subject of the following research question:

What is the relationship, if any, between practice change, resistance to change, and nursing rituals?

The reason that this study is significant to the development of quality assured nursing practice is that it will comment on how nurses perceive that their practice changes and the process that they go through to bring about this change. This knowledge could have an impact on the development of effective change strategies in practice at both local and national levels. The final research question therefore relates to the recommendations that are made as a result of the findings:

> What recommendations could be made to facilitate effective practice change?

3.3 Research questions

In summary the aim of this study is to investigate how nurses understand that their nursing practice changes and develops over time. The study will also research how nurses understand this process within their workplace and influencing factors, organisational, professional and personal. One of the influencing factors to be explored is the impact of nursing rituals and routines on practice change and development. The research will investigate if there is a process that nurses undergo as they change and develop their nursing practice over time, and how it manifests. The research questions have been influenced by both the researcher's background and literature review and therefore are as follows:

- How do nurses understand practice change and development, and how can it be described?
- What is the process that the nurse undergoes as their practice changes and develops over time?
- What is the relationship, if any, between practice change, resistance to change, and nursing rituals?
- What recommendations could be made to facilitate effective practice change?

CHAPTER 4

RESEARCH METHOD AND METHODOLOGY

4.0 Introduction

Chapter 4 will cover the research methodology and method that underpin this study. It will address the rationale and explore the choice of research paradigm – constructivist grounded theory – along with a critique of the method. The chapter will also discuss the design of the study, and data collection and analysis, along with how rigour will be ensured throughout the study. The theoretical framework will be introduced and elaborated upon further in the Discussion (Chapter 8).

4.1 Research methodology

4.1.1 Rationale for choice of research paradigm

One of the crucial factors to take into account when determining the choice of research methodology is the researcher's ontological beliefs and underpinning values. Ontology is the assumptions that the individual makes about the nature of reality and ideally there needs to be a philosophical fit between the methodological, theoretical context and the underpinnings of the study.

The features that drew the researcher to constructivist grounded theory are the iterative, inductive nature of the data analysis, which fits in with her own person centred, and reflexive approach. A constructivist grounded theorist views data as a construction located in time, place, culture and contexts, and 'an interpretive portrayal of the studied world, not an exact picture of it' (Gubrium & Holstein, 2002, p. 678). The constructivist slant on grounded theory according to Charmaz 'recognises the mutual creation of knowledge by the viewer and the viewed and aims towards interpretive understanding of subjects meanings' (Charmaz, 2000a, p. 510). This means that both the participants and the researcher construct the meaning and the ultimate theory that emerges from the data. In this respect constructivist grounded theory takes a reflexive approach where the researcher is viewed as located within the reality, and the researcher will impact on the data collected as they have their own interpretive framework, past experiences and own

research interests (Charmaz, 2005). A further feature of constructivist grounded theory is the nature of the relationship between the researcher and participants which aims to reduce power imbalances (Mills, Bonner, & Francis, 2006). This again fits into the researcher's values of equality, respect and unconditional positive regard. In order to facilitate a more equal sharing of power during the interview the researcher, who is a senior manager, fostered a relationship of 'one nurse to another'. Participants discussed their experiences using recognised nursing jargon and obviously assumed the researcher had a full understanding of the discussions that were taking place. Likewise, the interviews occurred in places and at times defined by the participants. Although an interview schedule was designed, participants were encouraged to direct the conversation and sharing of personal details and answering questions by the researcher was considered acceptable.

The choice of constructivist grounded theory method was also based upon the research questions and the applicability of the method in the context of the area of study. The aim of this thesis is to research the participants' understanding of their nursing practice changes and development and influencing factors. This thesis is concerned with the nature of practice change and development from a nursing perspective. It looks at what practice means to nurses and how they understand or construct changes in that practice. This incorporates the meaning that practice has to nurses' lives. The notion of 'meaning-making is the complex process through which existing meaning is reformulated in the midst of new experience and new meaning and understanding is developed' (Arbon, 2004, p. 153). This notion does not fit comfortably into the positivistic paradigm that aims to test hypotheses or existing theory through scientific measurement and experimentation (Jeon, 2004). The aim of the study is to develop a theory that arises from the participants' perceptions, understandings and constructions of nursing practice within their social context. Grounded theory takes a sociological as opposed to a psychological perspective and as such is the method of choice.

4.1.2 Theoretical framework to the study

The theoretical framework of choice for this study is structural anthropology with specific reference to the work of Levi-Strauss. Structural anthropology is one branch of anthropology that studies how human beings behave in their social groups, their customs, economic and political organisations, kinships, family structure, religion and other aspects of their social lives (Rapport, 2000). Levi-Strauss initially was very interested in the communication between groups in a society through language, the exchange of goods and services usually known as economics, and kinship which is the exchange of women. In later years Levi-Strauss moved away from the study of concrete social systems towards more symbolic systems such as classification and myths (Leach, 2008).

Modern anthropological ways of identifying myths are through functionalist, symbolist or structuralist modes of analysis, although their boundaries are not clear cut (Rapport, 2000). Levi-Strauss is associated with structuralism in social anthropology where his anthropological model can be seen as an extension of Saussure's linguistic theory as applied to the study of myth and culture (Kuo-Wei, 2006).

Myth, according to Levi-Strauss, is a form of language, and is necessary to understand the world as it is now and how it has developed (Levi-Strauss, 1966). Language itself predisposes construction of meaning through the interplay of words. The meaning of a word depends upon its juxtaposition or difference from other words along a 'right and left, good and evil, life and death continuum – these are inevitable dichotomies produced by the brain that has two lobes and controls two eyes, two hands' (W Doniger, 2009a, p. 197).

This thesis will use Levi-Strauss's concept of bricoleur and relate it to the nurse and nursing practice. Levi-Strauss associated the term bricoleur with extraneous movements, but it eventually became associated with someone who works with their hands and uses whatever is at hand to get the job done. The bricoleur can be compared to a craftsman, a jack-of-all-trades or a professional do-it-yourself man (Levi-Strauss, 1966, p. 16). The French term bricoleur has no precise equivalent in

English; jack-of-all-trades is the nearest and is a more respected terminology than the English odd-job man. The characteristics of the bricoleur are that they are resourceful, use whatever is available within the context, and will refer to a wide range of concepts, methodologies and approaches to inform practice and decision making. Levi- Strauss (1966, p. 17) compares the bricoleur to the engineer:

> '... [The bricoleur is] adept at performing a large number of tasks; but unlike the engineer, he [sic] does not subordinate each of them to the availability of raw materials and tools conceived and procured for the purpose of the project. His universe of instruments is closed and the rules of the game are to always make do with 'whatever is at hand', that is to say with a set of tools and materials which is always finite and is also heterogeneous because what it contains bears no relation to the current project, or indeed to any particular project, but it is the contingent result of all the occasions there have been to renew or enrich the stock or to maintain it with the remains of previous constructions or destructions.'

The engineer will seek out and use the resources needed for completion of the project. The bricoleur will use whatever is available, which may be abstract or concrete, and use their experience, knowledge and skills, and modify them to meet the needs of the project at hand (Louridas, 1999). Bricolage also has a long tradition within research and is used to describe the process of undertaking research that is based on a range of multidisciplinary theories and processes. The bricoleur researcher according to Weinstein, Weinstein and Simmel (1991) exhibits three characteristics: the first is that they are practical in what they do, secondly they are used to dealing with complex situations that start off one way and then take a different direction, and thirdly the result will be influenced by whatever resources are available at the time. A definition of the bricoleur as a researcher according to Denzin and Lincoln (2000) is:

> 'Jack-of-all-trades or a kind of do it yourself person who deploys whatever strategies, methods, or empirical materials that are to hand... If new tools or

techniques have to be invented or pieced together, then the studier will do this.'

This theoretical framework was chosen because of the nature of Levi-Strauss's research into the development of societies and their myths. Nursing has a strong tradition that is based upon differing and sometimes conflicting frameworks (rituals, evidence based practice, artistic nursing). Levi-Strauss's structural anthropology offers a mechanism for elucidating the myths that have been a part of the development of nursing practice as well as the modern frameworks of care.

4.1.3 Defining the grounded theory approach to be taken within this study

The method of choice for this study is grounded theory. Grounded theory has been identified as a research methodology, method, approach to data analysis, and as a means of identifying a theory which is for the most part applied to qualitative data (Outhwaite & Turner, 2007). The method emerged from work undertaken by Glaser and Strauss (1967) on patients' experiences of grief in the United States in the early 1960s. They collected data from patients who were dying and systematically applied rigorous analytic methods to the data. From this research emerged a series of methodological strategies that could be applied to the analysis of social situations. Grounded theory as identified by Glaser and Strauss included the following defining components: simultaneous data collection and analysis, using strategies to generate codes and forming categories from the data; the use of constant comparative methods throughout data analysis; and generation of theory as an integral part of data collection and analysis (Charmaz, 2006a). Glaser and Strauss also advocated memo writing in order to elaborate categories, and the relationships between categories and sub-categories. According to early work by Glaser and Strauss (1967) the literature review is generally conducted once data analysis is complete. Since this original work was completed in the 60s there have been significant shifts by researchers in the underpinning philosophy and methodological application of grounded theory. The two original exponents of grounded theory came from different epistemological perspectives. Traditional grounded theory is underpinned by the positivistic perspective and is often termed

'Glaserian Grounded Theory' (Cutliffe, 2005). This form of grounded theory assumes that there is one truth that will be uncovered (Charmaz, 2005; Seale, 1999). Glaser aimed to develop a series of explicit, systematic procedures for coding and testing theory, which he believed gave qualitative analysis equal rigor to that of quantitative (Eaves, 2001). Strauss on the other hand hailed from the Chicago School of Sociology and was influenced by interaction and pragmatist writings. The basic premises of symbolic interaction as described by Blumer (1969) are that humans act in response to situations on the basis of the meanings that the situations have for them; these meanings are a product of their social interactions in human society, and are modified and handled as a result of an interpretive process used by each person. In other words human beings construct their realities in a process of interaction with other human beings. These interpretations of grounded theory have been identified metaphorically as a methodological spiral which is a reflection of the underpinning epistemology of this method (Mills, Bonner, et al., 2006). Glaser, with his traditional grounded theory, is at the top of the spiral with constructivist method at the base.

Figure 1 is an interpretation by the writer of this methodological spiral, which is not identified in diagram form in the literature. Modernity in social sciences is based on the assumptions of 'universality, generalisation, simplification, permanence, rationality and homogeneity, whereas postmodernism has shifted the emphasis to localities, partialities, positionalities, tenuousness, heterogeneities, situatedness and fragmentation (A. E. Clarke, 2007, p. 367). This spiral then is a reflection of the postmodern turn (Mills, Chapman, Bonner, & Frances, 2006).

This study will use a constructivist theoretical grounded theory approach which is positioned at the bottom end of the spiral. This approach was identified by Charmaz (2000a) and builds upon a symbolic interactionism theoretical perspective with constructivist methods (Charmaz, 2002). Constructivist grounded theory takes social constructionist methods and adopts grounded theory guidelines as tools, but does not subscribe to the underpinning objectivist, positivist assumptions

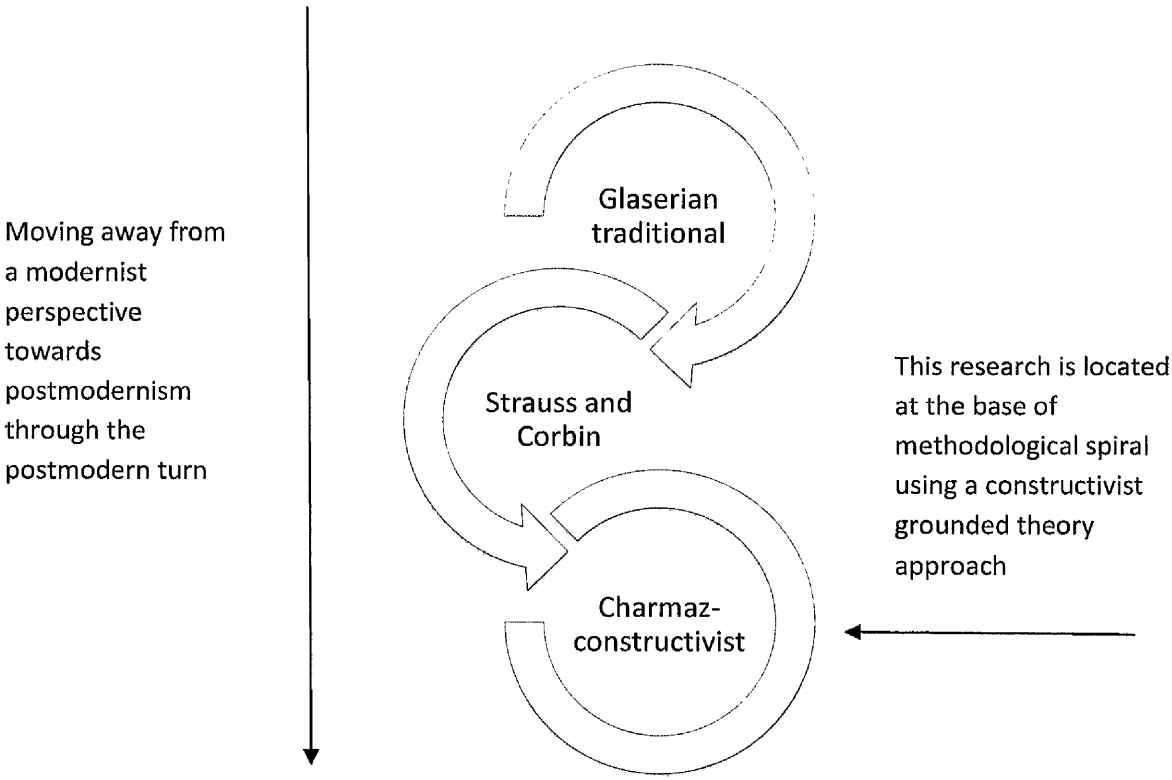

Figure 1: An interpretation of the methodological spiral of grounded theory as described by Mills et al (2006)

4.1.4 Critique of grounded theory

Many of the criticisms of grounded theory arise from the divergent paths that researchers have taken as the method has evolved over time. Part of this is due to the numerous interpretations and applications of grounded theory by researchers. There have been ongoing debates about the shift away from the purity of the original grounded theory method and the modified approaches that have emerged (Cutliffe, 2005). The literature is much divided with authors taking a strong stance for one methodological variation or another (Bryant & Charmaz, 2007; J. A. Holton, 2007), or comparing the differences between the recognised exponents (Heath & Cowley, 2004; McCann & Clark, 2003). These 'methodological hybrids' according to Cutliffe (2005, p. 422), who is an acknowledged exponent of Glaser's traditional grounded theory, can be divided into three categories: grounded theory approach, grounded theory methods and grounded theory research. Glaser (1992; 1998) is highly critical of these methods and refers to them all as qualitative data analyses as opposed to grounded theory.

One of the criticisms of traditional grounded theory, and the reason that it has left itself open to further interpretations, is that there is a lack of explicitness in regards to the research paradigm, associated ontology, epistemology and methodology (Charmaz, 2000a). Indeed grounded theory has been attributed as having elements of positivism, constructivism, interpretivism, pragmatism and realism by various researchers (J. A. Holton, 2007; Norton, 1999). They suggest that despite the principle of good practice that research design needs to clearly reflect the researcher's stance on knowledge and knowing, classic grounded theory transcends this concern and does not need to fit into any one established research paradigm. The underpinning premise to this is that 'any type of data sourced can be expressed through any epistemological lens' (J. A. Holton, 2007, p. 268). She went on further to say that grounded theory methodology can be seen as epistemologically and ontologically neutral (J. A. Holton, 2007, p. 268). The rationale for this divergence away from the need to declare a philosophical position is justified by Glaser (2002) who believes that, when using grounded theory, data can take many forms; and the notions of bias and subjective or objective data are less relevant when the goal is to develop a conceptually abstract theory that holds significance within the social setting. These varying perspectives leave the researcher, particularly the novice researcher, with serious challenges as to which variant of grounded theory to subscribe to.

Compounding these confusions is the variety of data analysis methods associated with the differing interpretations. Strauss and Corbin (1998) offer a very structured approach with a highly formulistic set of procedures. This may be attractive to the novice researcher, but has been criticised for its over reliance on predetermined coding procedures which may lead to description as opposed to discovery, and forcing as opposed to emergence (Goulding, 2002; Melia, 1996). Glaser (1992) , on the other hand, advocates a more flexible, less structured approach with the underpinning premises that the researcher goes into the field without any preconceptions or even research questions or aims. Glaser (B G Glaser, 1992, p. 22) refers to this as 'abstract wonderment' and believes that the issues that emerge will belong to the participants, and will not be the preconceived ideas of the researcher.

In reality this unstructured approach is not always practical. Research studies are required to clearly demonstrate an overall structure and projected outcomes, and research in healthcare is conducted within severe constraints of organisational systems which are concerned with value for money and evidence based practices. Submitting application for doctoral study, seeking external funding and the resulting applications for ethical approval all require early detailed information on the research proposal, research questions and the substantive focus of the study, which have to be identified before the study commences. Failure to provide these may disadvantage the applicant's success (Cutliffe, 2005).

Ansell (1997) suggests that this diversification of the method is a natural evolving maturation which is to be expected as researchers use the method over time. Similar development has occurred in other research approaches, such as the philosophical school of phenomenology originally developed by Husserl, and later modified by Heidegger because of what he perceived as underlying subjective tendencies (Moran, 2000). As with grounded theory, several data analysis approaches also exist for phenomenology (Colaizzi, 1978; Giorgi, 1975; Van Manen, 1990). In addition, the development of traditional grounded theory reflected the emphasis during the 1960s on quantitative research, variable analysis and objective approaches. Glaser's grounded theory was an attempt to identify a means of undertaking systematic qualitative research that would hold its own and have equal significance with the statistical, quantitative research methods that prevailed at that time (Charmaz, 2006b). There have been major philosophical and scientific shifts since the 1960s, away from the modernist phase which ended in the 1970s and characterised by three features: a quest for respectability, realist ontology and a focus on the common person (Charmaz, 2004). Charmaz believes that traditional grounded theory is situated at the end of the modernist phase. Researchers such as Charmaz offered a more eclectic approach with the identification of constructivist grounded theory, which sat between post modernity and objectivity, and addressed the tensions that arise due to the positivistic notions of truth and reality.

Clarke (2007) suggests that over the forty years that grounded theory has been in use the main problems relate to how rigorously researchers apply the method. She

suggests that the method is too esoteric and difficult to learn unless via an apprenticeship, there can be slippage or method slurring between grounded theory and phenomenology, and the use of too small a sample or number of participants may lead to the data being over theorised and/or over generalised.

True theoretical sampling is very difficult to achieve in the real world. Studies tend to start off using purposeful or selective sampling which should naturally move towards theoretical sampling as on-going data analysis and category and theory development take place. A grounded theory that is derived from a purposive sample may lack conceptual depth (McCann & Clark, 2003). The majority of research studies in healthcare take place in a context which demands accountability and ethical approval. To move between samples may not be realistic within the timescales involved in achieving ethical approval. Most researchers decide upon a sample that they believe will generate the data required and undertake theoretical sampling within the context of the interview situation. This was the stance taken within this study. Analysis was undertaken after each interview and theoretical sampling was achieved through the direction and content that was explored during the interview. A further challenge with theoretical sampling is identifying when saturation is achieved, and, therefore, when to withdraw from the field.

Challenges with data analysis that researchers may encounter with the use of grounded theory relate to being 'analysis light' (A. E. Clarke, 2007, p. 228). These may include the generation of thematic analysis rather than action analysis of the basic social processes related to the domain of enquiry (A. E. Clarke, 2007), and the under analysis of data with the identification of categories based upon phenomena that are underpinned by insufficient evidence (Goulding, 2002). Further challenges include the difficulty of producing an analytical rather than a descriptive study with failure to move analytically from codes to categories. Studies rarely include analytical diagrams that lay out the basic forms of action/processes in the substantive area studied and the conditions that affect them, which would enhance the analysis (A. E. Clarke, 2007).

Charmaz (2004) discusses the challenges relating to the claims that some researchers using grounded theory make about portraying an insider's view of an experience. She suggests that this is very difficult to achieve and most studies go around the topic instead of inside it: 'Rather than offering an incisive analytic interpretation of the experience as lived, qualitative studies often offer a description that defines it as observed – from a distance' (Charmaz, 2004, p. 980). This can be particularly pertinent when the method of data collection is by interview alone. Charmaz puts forward some strategies that could be used to facilitate this process: 'Being fully present during the interview and deep inside the content afterwards' seem obvious, but not so easy to achieve when the discussion is on sensitive subjects (Charmaz, 2004, p. 981). This entering the phenomenon means being able to 'sense, feel and fathom what having this experience is like' (Charmaz, 2004, p. 981). To fully understand the meanings in a situation and the relevance to participants can lead to a process of personal bewilderment, which Charmaz sees as a sign of entering the phenomenon (Charmaz & Mithchell, 1996). Being bewildered can lead to insight and illuminate hidden meanings.

4.2 Research methods

4.2.1 Managing the data

The term 'grounded theory' can relate to a method of inquiry and the product of the inquiry, as well as being a specific approach of analysis (Charmaz, 2005). Despite the methodological controversies, there exists a fundamental set of principles associated with grounded theory. This section will explore the design of the study, identifying the stages that will be undertaken for data collection, method of data analysis and theory development.

4.2.1.1 Population to be studied and access

The study was conducted in two parts. The first part involved interviewing eight participants from one acute NHS healthcare provider organisation. They had all been identified as Nurse Champions for Older People which was an addition to their existing role. The second part of the study involved interviewing eleven members of an early intervention team (EIT) in one NHS Partnership healthcare provider

organisation. Participants for the second part of the study were not identified until all data had been collected, transcribed and analysed from part one. This meant that ethical approval had to be sought twice during the research.

A purposive, or purposeful sample as it is sometimes referred to, was used to identify participants for the first part of the study. Sample selection was informed by prior knowledge of the services in which the participants worked and theoretical work undertaken during the literature review. Access to the setting is usually through a gate keeper, someone who is in a position to allow and facilitate the research (Pope & Mays, 2000). Initial access to the nurse champions was via the Directorate Manager who was leading the Nurse Champions Project. In order to recruit participants, the researcher presented an overview of the study and explained what potential participants could expect from their involvement at one of the champions study days. The nurses were then invited to volunteer to be included in the study. The role of nurse champion was implemented from the National Service Framework (NSF) for Older People (Department of Health, 2001a) to act as a resource for good practice, to facilitate consistently high standards of nursing care for older people, and act as role models for colleagues. For a nurse champion to be included in the sample they must have been identified as a healthcare provider organisation nurse champion been qualified at least one year, and involved in patient care on a daily basis.

The nurse champions were chosen because they were undergoing a period of development within the healthcare provider organisation through a series of audits and workshops. The perception was that they would be changing or developing their practice accordingly and in a position to discuss their experiences. The first two interviews were completed and analysed, and subsequent interviews were used to explore the developing categories.

The choice of participants for part two of the study was based on the principle of theoretical sampling. 'Theoretical sampling is the process of data collection whereby the researcher simultaneously collects, codes and analyses the data to decide what data to collect next' (Coyne, 1997, p. 625). This sampling method is

peculiar to grounded theory and is not driven by the need to provide data that represents a whole population, or social body. The main purpose of theoretical sampling is to seek data that will contribute to the development of the emerging categories and subsequent theory that has arisen from previous data analysis (Charmaz, 2006a). Participants for part two were chosen following ongoing analysis of the data provided by the nurse champions. They were nurse members of Early Intervention Teams across four localities within one NHS Partnership healthcare provider organisation. These are multi-disciplinary teams whose primary aim is to improve the outcome for clients between the ages of seventeen to thirty, presenting with either first episode psychosis or ongoing illness. The aims of early intervention in psychosis are to reduce the time between the onset of psychosis and the commencement of treatment, offering effective treatment at the earliest possible point and ensuring that the intervention constitutes best practice for this phase of illness. A further aim is to reduce the incidence of hospitalisation through early intervention and support clients within their own settings (Singh & Fisher, 2005). A key element of early intervention is raising awareness of psychosis, and how it can affect people within the local community. This involves the teams making presentations to schools, colleges, youth clubs and other organisations that support the client age range.

The early intervention teams have been in existence since 2006. Although the service belongs to one NHS healthcare provider organisation, they are geographically disparate. The healthcare provider organisation was formed in the NHS restructure of 2001 when mental health and learning disabilities services were removed from acute healthcare provider organisations and put into specialist NHS healthcare provider organisations. These participants were chosen for several reasons. The categories that were emerging from the analysis of part one were about the role of the day-to-day experiences and how they impact on the development of nursing practice. The early intervention team were mental health nurses and the perception was that they worked in a much more experiential way than nurses in the acute sector. Also, team members have had to develop new skills on commencing the role and throughout the development of the team. Thus, their

practice should have been developed and changed as they took on this new role. A presentation was made to the teams and access to the early intervention teams was through the individual team manager.

4.2.1.2 Data collection

The choice of data collection method within a study is denoted by the research questions, and by the researcher's ontological perspectives and underpinning research methodology (Silverman, 2001). The data required in this study is how the participants perceive, understand and make sense of how their nursing practice has changed and developed over time, and the factors that facilitate or hinder this process. Thus the data collection method needs to facilitate the exploration of these perceptions, meanings, understandings, and social processes around this changing practice.

The research used in- depth interviews for data collection, as identified by Charmaz (2006a). In-depth interviewing facilitates the participants' interpretation of his or her experiences, using techniques which aim to go beneath the surface of ordinary conversation and would not be applicable in day-to-day interactions. Examples of these techniques include stopping to explore a statement or topic, asking about the participants' feelings, thoughts and actions, summarising and reflecting on parts of conversations, keeping the participants on the topic and going beneath the surface of the described experience (Charmaz, 2006a). The nature of the data or knowledge that is required to answer the research questions is situational and contextual in that it draws upon, or conjures up as closely as possible, the social experiences around the processes that are being explored. Contextual knowledge can be elicited by the exploration of specific experiences within participants' lives. This was achieved in the study by asking participants to identify and discuss specific clients or situations, requiring them to make judgements and use reasoning that subsequently led to them changing their nursing practice. Situated knowledge is knowledge specific to a situation and may include social processes, change, meanings or organisation (Mason, 2002). The knowledge in this study is situated within nursing and the specific field within which the participants practice.

This method of in-depth interviewing is congruent with constructivist grounded theory, which is the method of choice for this study. The role of the interview is to bring the context to the fore and expose the situated knowledge. Data and knowledge are constructed, or at least reconstructed, through dialogue and other interactions during the interview, as opposed to just being reported.

Qualitative interviewing therefore tends to be seen as involving the construction or reconstruction of knowledge, and understanding more than the excavation of it (Kvale & Steinar, 2009; Mason, 2002). These constructions or reconstructions are not necessarily a reflection of the meanings and understandings outside the interview (Mason, 2002). These meanings and understandings are also dependent upon the participants' abilities to verbalise, conceptualise, and remember events and happenings in their lives.

In-depth interviewing allows the exploration of a range of topics and the interviewer is free to alter the sequence and probe for more information within the interviews. This type of interview also allows the participant to have some freedom in the direction that the interview takes.

Before commencing the interviews the interview schedule was piloted on a small sample of participants. Three in-depth interviews were undertaken with two volunteers from the nurse champions and two from the early intervention teams for both parts of Study 2: A and B. The interviews were taped, transcribed and analysed to assess the effectiveness of the questions asked. Minor amendments were made to all of the questionnaires before they were used.

The nurse champions were interviewed for approximately an hour each and the data transcribed by the researcher and used for analysis. Appendix 2 is an example of one of the transcribed interviews. The members of the early intervention team were interviewed for the first time for approximately an hour and a half, and subsequently for a further half an hour three months later.

The second interview specifically asked about resistance to aspects of organisational change within their careers and included the use of a vignette. 'The

vignette technique is a method that can elicit perceptions, opinions, beliefs and attitudes from responses or comments to stories depicting scenarios and situations' (Barter & Renold, 1999, p. 2). The vignette in this instance was used as an ice breaker and a lead into exploring participants' experiences throughout their careers on the subject introduced via the vignette (see appendix 3). All interviews for all parts of the study were taped and transcribed prior to analysis, with permission from participants.

4.2.1.3 Method of data analysis

The aim of a research study using grounded theory is the generation of a theory. A theory can be defined as 'a set of well-developed categories, themes and concepts that are systematically inter related through statements of relationship to form a theoretical framework that explains some of the relevant social[,] psychological[,] educational[,] nursing or other phenomenon' (B G. Glaser & Strauss, 1967, p. 32).

Depending on the ontological approach a theory can have differing perspectives. This study will use constructivist grounded theory (as opposed to an objectivist grounded theory). Within this paradigm the theory will be an interpretation which is inductive, emerges from the data, is based on multiple realities, emphasises understanding and sometimes explanation, and sees social life as a process and truth or reality as provisional (Charmaz, 2006a). A constructivist grounded theory aims to define conditional statements that interpret how participants construct their reality. The theory addresses how, and sometimes why, participants construct meanings and actions in specific situations. It enables exploration of meaning that is situated within the wider context of the participants' world, and may include such issues as hierarchies of power, network situations and relationships. The theory aims to portray an insider's view of their world and in order to achieve this premise the researcher needs to see their experiences from inside the phenomenon: 'Entering the phenomenon means being fully present during the interview and deep inside the content afterwards' (Charmaz, 2004, p. 981). These assumptions are compatible with those of symbolic interactionism and Blumer's 'intimate familiarity' with the respondents and their worlds (Blumer, 1969, p. 188). Intimate

familiarity with the phenomenon means 'gaining a level of knowledge and understanding that penetrates the experience' (Charmaz, 2004, p. 984). Thus, it can be seen that a true constructivist grounded theory is one that offers an interpretive rendering of the participants' world from the inside.

Charmaz (2006a) suggests that using grounded theory methods and theorising are social actions that the researcher constructs in conjunction with others that are significant within the situation: 'The viewer is then part of what is viewed rather than separate from it' (Charmaz, 2000b, p. 524). The theory emerges from interaction between the researcher and the participant and is based closely on the meanings that are made, taking into account values, beliefs and ideologies within the context and situation that the research is taking place.

4.2.1.4 Theory development following data analysis

Strauss and Corbin (1998) suggest that analysis is the interplay between the researcher and the data which leads to the grounded theory. Data analysis is a series of stages which are made up of coding strategies. Coding is significant in all qualitative research methods of data analysis, and there are two types of coding: substantive and advanced which, along with memo writing and theoretical sampling, are the elements of theory building (Duchscher & Morgan, 2004). Codes are tags or labels for assigning units of meaning to the data that has been collected during the study. In qualitative interviewing codes are chunks of words, phrases, sentences or whole paragraphs that set up a relationship with the participants (Miles & Huberman, 1994). The process of coding is the link between data collection and the development of the emerging theory (Charmaz, 2006a).

There are a range of coding strategies available to the researcher according to which version of the method is used. This study used a version that is identified in figure 1 and includes coding mechanisms taken from an amalgamation of the work of Strauss and Corbin and Charmaz (Eaves, 2001). The researcher chose these strategies because they allow for the inductive process to take place, are not too formulaic, as some of Strauss's strategies appear to be, and yet offer a clear

framework to follow. The process is identified in a linear fashion, whereas in reality the stages go backwards and forwards as comparisons are made.

The first stage in the process is line by line coding where the data is coded to reflect actions. See appendix 3 for an example of line by line coding. Codes may either emerge spontaneously from the data or from previous experiences and expectations of the researcher. This use of action codes is one of the fundamental differences between Glaser's and Charmaz's approach to coding (Charmaz, 2006a), and enables constructivist grounded theorists to seek codes that reflects participants' values, beliefs and ideologies (Mills, Bonner, et al., 2006). These initial codes are provisional, because they will probably develop with further analysis, or may be reworded to improve the fit. Likewise, these provisional codes will also highlight gaps or holes in the data which the researcher can explore during ongoing data collection (Charmaz, 2006a).

The initial codes can take several forms. In vivo codes are words that participants identify during data collection and serve as 'symbolic markers of participants['] speech and meanings' (Charmaz, 2006a, p. 55). There are many forms that these codes can take and three examples are: terms that are familiar to participants; types that can be attributed to one individual, such as the 'personal process of practice change and development', which was a term identified in the first study by one participant; and terms that pertain to a specific group and reflect their own particular perspective. Both Glaser (1978) and Charmaz (2006a) suggest coding using gerunds, which is the noun form of a verb, such as revealing, defining, wanting. This gives a strong sense of action, turns the nouns into topics, stays close to the data, and if possible uses the words and phrases of participants. Charmaz also identifies incident to incident coding through a comparative study of incidents in the data. These initial coding strategies also enable the researcher to identify gaps in the data and collect more data to address it.

Focused coding followed line by line coding and this involved producing codes that are more 'directed, selective and conceptual' (B G Glaser, 1978, p. 37). The aim of focused coding is to begin to identify categories from the most significant and

frequently identified initial codes. Categories can be identified as a series of concepts that stand for phenomena (Strauss & Corbin, 1998). Phenomena are central ideas in the data that are represented as concepts which are the building blocks of theory.

The next stage in the data analysis is axial coding. This form of coding emerged from the work of Strauss & Corbin (1998), and is where categories are related to their sub-categories and data that were originally fractured are brought together into a coherent whole. The relationships within the data are built up around the axis of the category. As part of this process the researcher looked for the properties or dimensions of the category along a continuum or range. Properties are characteristics of a category, the delineation of which defines and gives it meaning. Dimensions can be defined as the range along which general properties of a category vary, giving it further clarification and specification.

Both Glaser and Strauss and Corbin offer further advanced coding strategies that facilitate the identification of relationships within previously identified categories between broad conditions, properties and consequences (Duchscher & Morgan, 2004). Theoretical coding is an alternative strategy to axial coding and is a process that enables the researcher to 'weave the fractured story back together' (B G Glaser, 1978, p. 72). The conditional consequential matrix is an abstract analytic device identified by Strauss & Corbin (1998), a further coding strategy that enables the researcher to become more sensitive to the conditions and consequences that surround the actions and interactions of participants in the study (W. Walker & Myrick, 2006). These are highly structured approaches, with Glaser identifying as many as nineteen coding families available to the researcher. A choice was made not to include these tools in the data analysis as they are very formulaic and force the researcher down preconceived pathways (Melia, 1996).

The constant comparative method is central to grounded theory and used throughout the coding process. This involves making comparisons between data, codes and categories, and subjecting those categories to rigorous scrutiny (Charmaz, 2006a). The constant comparative method can involve comparing

different peoples, views, situations, actions, accounts and experiences; comparing data from individuals at differing times or interviews; comparing data with category; and categories with other categories (B G Glaser, 1992) . The process involves identifying similarities and differences between emerging categories and then deconstructing them into smaller units of meaning. As categories are being refined during the coding process, gaps emerge in the data. Theoretical sampling is the on-going collection of data in order to fill in the conceptual gaps and to make the emerging categories more definitive and useful (Charmaz, 2000a). Theoretical sampling enables the definition of the properties of categories, identifying the context within which they exist, specifying the conditions under which they arise and discovering their consequences.

Writing memos is used throughout the coding process and is one of the cornerstones of grounded theory. This is the writing up of theoretical ideas as data is analysed, and is the link between coding and writing up the theory. The process can be used to develop properties of categories and is the first stage of theory development (Charmaz, 2006a; Duchscher & Morgan, 2004). Memoing is also used in the identification of sub-categories and relating a category to its sub-category through statements denoting how they are related to each other. A further function of memos is the conceptualising of ideas that were previously descriptions. Charmaz (2006a) identifies two types of memo: initial and advanced. Initial memos are used to raise codes to tentative categories, and advanced ones to refine conceptual categories.

4.2.1.5 Data analysis within this study

The process of data analysis within this research followed the process identified in figure 1. Once the first two interviews were completed, initial line by line coding was undertaken by hand in the right hand margin of the transcript. Focused coding was then undertaken using the software package NVivo 7.0. This package allowed the researcher to create codes in the form of free and tree nodes. Initial focused coding identified free nodes, which stand alone and have no apparent connection with other nodes. As data were further analysed, codes were confirmed and then

assigned as tree nodes. Tree nodes have properties of free nodes but can be presented as a hierarchy of codes. These are denoted as parent and child nodes. Parent nodes developed into categories as analysis continued, and child nodes became the sub-categories. The advantage of using this software is that data can be linked to relevant codes and easily accessed for further analysis. Memos can also be generated and linked to the data as well as annotations, which are comments that arise as analysis is ongoing. Text queries or searches were undertaken as the theory developed. Figure 2 is an example of the tree/parent node 'Experiencing Practice' showing the associated free and child nodes.

Memos were written extensively throughout the analysis process. Appendix 5 is an example of a memo written at the end of part one of the study. Memos were used to identify the properties, characteristics and dimensions of the categories, and links between categories, as well as comment on the developing theory. Diagrams were also used to represent the developing theory; appendix 6 is an example of a diagram drawn early on in the research to represent the process of practice change and development. Constant comparative analysis and theoretical sampling were key processes in the development of the categories and developing theory.

Free nodes		
Influence of personal experiences on the self Positive experiences Negative experiences Past experiences Patient influences Colleagues External influences Organisational impact on practice Using evidence/research in practice Learning from experience	Own personal values in practice change: caring, respect for other, justice Personal philosophy: Supporting practice Conflicting with practice Personal experiences and influencing practice change	What being experienced means Valuing sharing experience Changing practice with experience
Parent node: **EXPERIENCING PRACTICE**		
Child nodes:		
The nature of experience in practice	Personal values and nursing practice	Being experienced

Table 1: Example of the tree/parent node 'Experiencing Practice' with some of its associated free and child nodes

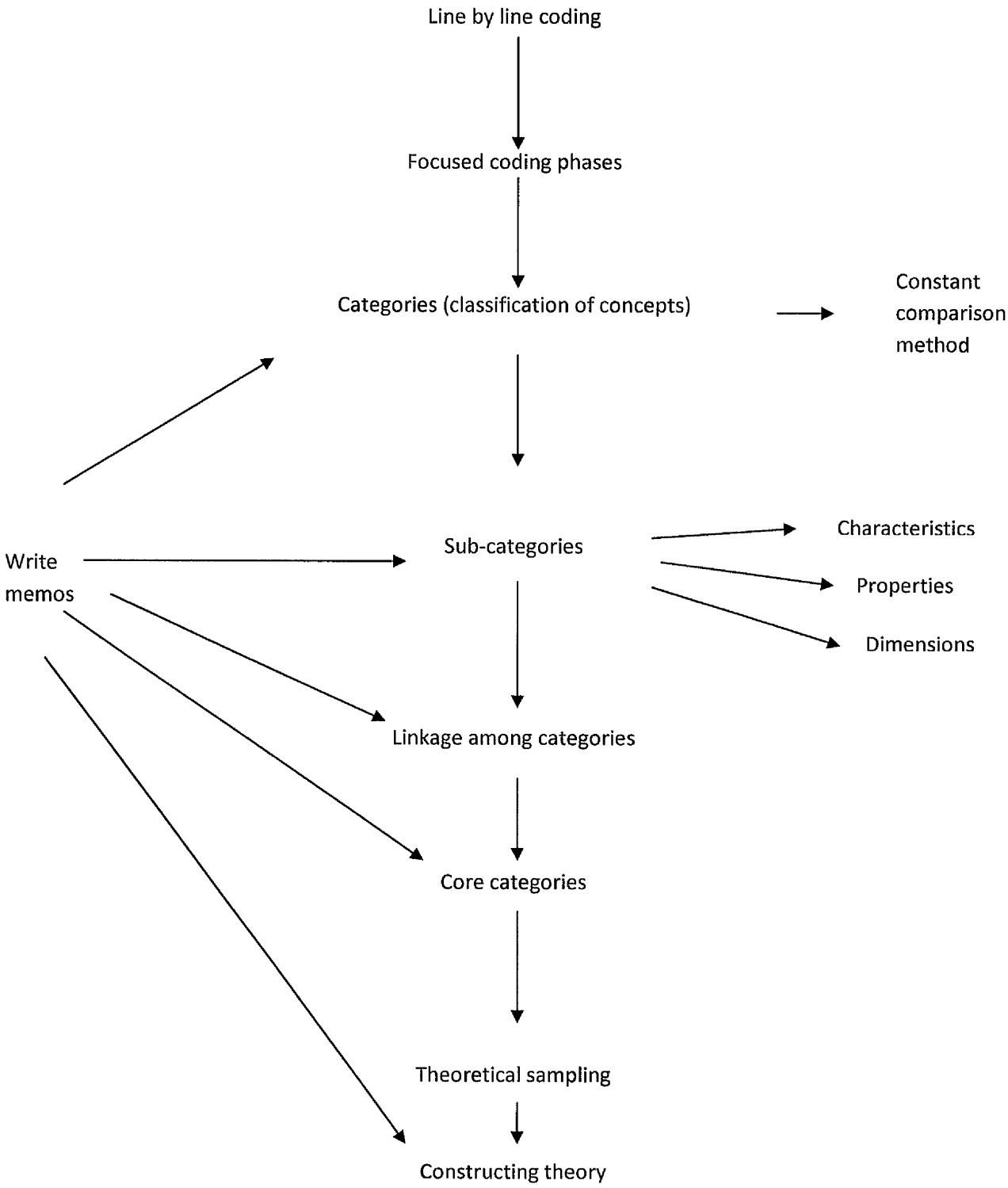

Figure 2: Diagrammatic representation of the process for data analysis undertaken during all parts of the study (Charmaz, 1983)

4.3 Ensuring rigour and ethical considerations

It is essential to demonstrate rigour within any research as 'without rigour, research is worthless, becomes fiction, and loses its utility' (Morse, Barrett, Mayan, Olsen, & Spiers, 2002, p. 1). Davies and Dodd (2002) suggested rigour in application to research can be identified according to the context in which it is used. They suggest that rigour in research encompasses detachment, objectivity, replication, reliability, validity, exactitude, measurability, containment, standardisation and rule (C. Davies, A, 2002, p. 280). The commonest criteria used for demonstrating rigour in research are validity and reliability.

Ethics are an essential part of rigorous research and have historically been linked to gaining ethical approval from professional or academic bodies prior to undertaking data collection. The criteria that these committees use centre on participant protection, confidentiality and anonymity (Birch & Miller, 2002). Ethics relates to the morality of human conduct and can be identified as 'moral deliberation, choice and accountability on the part of the researchers throughout the research process' (Edwards & Mauthner, 2002, p. 14). This section will identify the framework and strategies used during the study for facilitating rigour and ensuring an ethical approach was taken to the research.

4.3.1 Rigour

There is substantial controversy around the quantitative and qualitative methods used to ensure rigorousness of research. A number of qualitative researchers argue that reliability and validity are terms that could reasonably be applied only to quantitative research, and are not pertinent to qualitative research as they are based on different epistemological and ontological assumptions, making the validity criteria of the quantitative perspective inappropriate (Guba & Lincoln, 1989; Leininger, 1994). It has been suggested that the distinction between internal and external validity in quantitative research has less relevance in qualitative research where generalisability to populations is not necessarily a significant research goal (Leininger, 1994). Reliability and validity have been replaced in qualitative research by criteria and standards for evaluation of the overall significance, relevance,

impact, and usefulness of completed research. Lincoln and Guba (1985, p. 290) substituted reliability and validity with 'trustworthiness', which includes four aspects: credibility, transferability, dependability, and confirmability.

Credibility is confidence in the truth of the data and the interpretation of it (Polit & Beck, 2006). Charmaz (2006a, p. 182) offers a series of questions that can be applied to confirm credibility: has the research achieved intimate familiarity with the setting or topic? Is the data sufficient to merit the claims taking into account the range, number and depth of observations contained in the data? Have systematic comparisons been made between observations and categories and do the categories cover a wide range of empirical observations? Are there strong logical links between the gathered data and the argument and analysis? And has the research provided enough evidence for the claims made to allow the reader to form an independent assessment and agree with the claims stated?

Polit and Beck (2006) suggest that dependability refers to the stability of the data over time and over conditions. Transferability refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. This is not to suggest that the data should be generalisable to a whole population, but able to confirm what was meaningful in one specific situation or with one specific group (Macnee & McCabe, 2006). Confirmability refers to the consistency and repeatability of the decision making during data collection and analysis.

Specific methodological strategies for demonstrating qualitative rigour through these criteria included evidence from audit trails, peer debriefing and member checks when coding, categorising, or confirming results with participants. One approach to ensuring dependability is to undertake a stepwise replication and have teams of researchers who conduct data collection and analysis, comparing conclusions at the end (Sparkes, 2001). This is not always practical or possible unless specific funding is available. Further strategies include inquiry audit which includes a scrutiny of the data and relevant supporting documents by an external reviewer, searching for disconfirming evidence and negative case analysis,

prolonged engagement and persistent observation, and researcher credibility (Patton, 2002).

Morse et al. (2002) challenge whether these procedures can be used to make a judgement on the trustworthiness of the study as they are external to the research process. Audit trails might demonstrate decisions made throughout the study but do not reflect the quality of decision making, rationale behind those decisions, or the responsiveness and sensitivity of the investigator to data. Audit trails also might not identify any shortcomings in the research. Returning to original participants to undertake member checks can be problematic as data analysis has resulted in an outcome that has been synthesised, de-contextualised, and abstracted from individual participants, so there is little chance of individuals being able to recognise themselves or their particular experiences (Morse, et al., 2002; Silverman, 2001). Being responsive to the concerns of individual members as a result of presenting the analysis to participants can keep the level of analysis inappropriately close to the data and result in a more descriptive level of analysis.

One of the challenges with Guba and Lincoln's criteria for trustworthiness is that the researcher focuses on the outcomes of the research and they are externally verified, rather than embedding strategies that shape and direct the research overall. Strategies of trustworthiness may be useful in evaluating rigour; they do not in themselves ensure rigour or relevance and usefulness (Morse, et al., 2002). Despite the criticisms of Guba and Lincoln's notion of trustworthiness, it never the less is regarded as the gold standard in the literature (Polit & Beck, 2006; Whittemore, Chase, & Mandle, 2001), and trustworthiness was one of the criteria used to ensure rigour within this study.

Morse et al. (2002) also suggest a series of verification strategies as a means of embedding rigour into the research process, as opposed to evaluating the research outcome. These strategies include ensuring methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis, thinking theoretically, and theory development. These strategies enable the researcher to correct any issues with the design, development and

analysis as they arise within the study, thus contributing to the rigour of the completed project. Verification is the process of checking, confirming and ensuring that these mechanisms are embedded into every step of the research (Morse, et al., 2002). The research becomes iterative as opposed to linear, and there is constant evaluation of fit between all aspects of the research process.

Methodological coherence is ensuring that there is congruence between the research question and the components of the method, grounded theory in this instance. High quality qualitative research demands that the research question matches the method and analytic procedures which may not be a linear process as data is collected and analysed. There needs to be coherency between the components of the research design with each verifying the previous component and the methodological assumptions as a whole.

Second, the sample must be appropriate, consisting of participants who best represent the research topic. The use of effective theoretical sampling when using grounded theory is crucial and the process continues until saturation of categories is achieved. Sampling adequacy, evidenced by saturation and replication, means that sufficient data have been collected to account for all aspects of the phenomena that have emerged (Morse, et al., 2002). Saturating data ensures replication in categories; replication verifies, and ensures comprehension and completeness. Thinking theoretically can be thought of in grounded theory as theoretical sensitivity: 'an ability to have a theoretical insight into one's area of research combined with an ability to make something of one's insights' (B G. Glaser & Strauss, 1967, p. 46). The researcher needs to have competence and knowledge of the research as well as an analytic temperament (Charmaz, 2006a). The constant comparative method is also a component of theoretical thinking where ideas emerging from data are reconfirmed in new data; this gives rise to new ideas that, in turn, must be verified in data already collected. Lastly, the aspect of theory development is to employ a data analysis strategy that moves between a micro perspective of the data and a macro conceptual/theoretical understanding. In this way the resulting theory is developed as an outcome of the research process,

rather than being adopted as a framework to move the analysis along; and as a template for comparison and further development of the theory.

Within this study strategies for both trustworthiness and verification were used. Strategies to demonstrate trustworthiness include the use of NVivo 7.0, a qualitative data analysis software programme. Data analysis was undertaken by the researcher and the software used as a tool to facilitate the process. NVivo 7.0 offers coding facilities, and the ability to add annotations to the data, as well as the production of memos and diagrams which can be flagged and linked to relevant sections of the data. This software package offers the ability to demonstrate a clear audit trail during data collection and analysis.

The nature of supervision during studying for a PhD may contribute to peer debriefing. An annual presentation to peers including supervisors is a requisite for extending registration into the next year, as well as external scrutiny of the year's progress. Students are encouraged to present their work at conferences where peer review takes place, as well as publishing in peer reviewed journals. This research has been presented annually to peers at conferences. One book chapter has been published from the literature review. When the final thesis is marked, some of the criteria used by the reviewers will contribute to the verification process. Member checks during the research process take place as part of theoretical sampling. Grounded theory requires the researcher to undertake on-going data analysis which informs data collection. By the very nature of this iterative process, the previous findings are discussed with participants in an on-going process.

Researcher credibility is enhanced by the initial requirements of the institution's Research Committee for a level of academic attainment and the provision of some mandatory education on research methods which takes place during the implementation of the research. Training events have been attended on topics such as ethical aspects of research, undertaking a literature review, writing up the thesis and poster presentations. Theoretical sensitivity can also contribute to researcher credibility. The researcher's credibility is built on the fact that she is a nurse by

background and taught salient features of this research for many years, including Managing Change and Reflection. She undertook a qualitative piece of empirical research as part of a Master's Degree on change and integration into a new organisation, and gained a distinction for the dissertation.

The verification process has been checked in an on-going way; during the initial registering for PhD studies where all aspects of the research design are evaluated before registration is confirmed, and then as part of the annual review process, as well as during the transfer process from M Phil to PhD. The examiners during the final review will also be judging methodological coherence.

4.3.2 Reflexivity

Reflexivity has been established as an integral part of qualitative research with the recognition that the researcher may have a significant influence on the selection, collection and interpretation of data ((Dowling, 2006; Finlay, 2002; Lambert, Jomeen, & McSherry, 2010). The process of reflexivity is therefore a concept of qualitative validity (Lambert, et al., 2010; McCabe & Holmes, 2009) as well as keeping the researcher aware of bias that may affect the research outcome.

Parahoo (2006, p. 326) defined reflexivity as 'the continuous process of reflection by the researcher on his or her values, preconceptions, behaviour or presence and those of the participants, which can affect the interpretation of responses'. This involves researchers recognising that they are part of the social world under study.

There are overlaps between the processes of reflection and reflexivity. Reflexivity is identified in the literature as a focused reflection on one's relative ability to be unbiased while also recognizing and considering the effect of one's existing biases on the research. At its most basic level, this may include raising researcher awareness of how their presence affects the research process and participants, as well as how the participants affect the researcher. Applied in this manner, reflexivity is the process of analysing how various elements affect and transform the research (Finlay, 2002). Reflecting on the process of one's research and trying

to understand how one's own values and views may influence findings adds credibility to the research and needs to be part of any method of qualitative enquiry (Charmaz, 2004).

Reed & Procter (1995) recognised the potential influence of the researcher during research that uses inductive methods, on all aspects of the research process including the selection of participants, data analysis and findings. They consider that the researcher occupies one of three positions: 'outsider', 'hybrid' or 'insider'. The 'outsider' is a researcher with no professional experience and a visitor to the area of study. The 'hybrid' is a researcher who undertakes research into the practice of other practitioners and is familiar with that research area. The 'insider' is the actual practitioner-as-researcher looking into their own and known colleagues' practice. These positions were presented as a continuum, with the researcher moving backwards and forwards along it as they engaged with the research process (Reed & Procter, 1995). Figure 3 identifies this continuum and highlights where the researcher of this study considers herself to be placed. This position is between the insider and hybrid. The 'insider' position was relevant in that she had existing knowledge of the background within which the participants came from due to her professional working life, but was not fully inside as she did not know participants or the service personally before the study.

Mechanisms undertaken in order to promote reflexivity were as follows; notes were made after each interview to identify when the researcher believed that she influenced the research process and interviews were recorded and transcribed in order to reinforce and gain awareness of the subtle ways that data collection may have been affected. Account was taken of this influence during data analysis. Openly acknowledging the influence of prior work and experience, as well as utilising memo writing were used to raise awareness of the researchers potential effects on the data (Charmaz, 2006a).

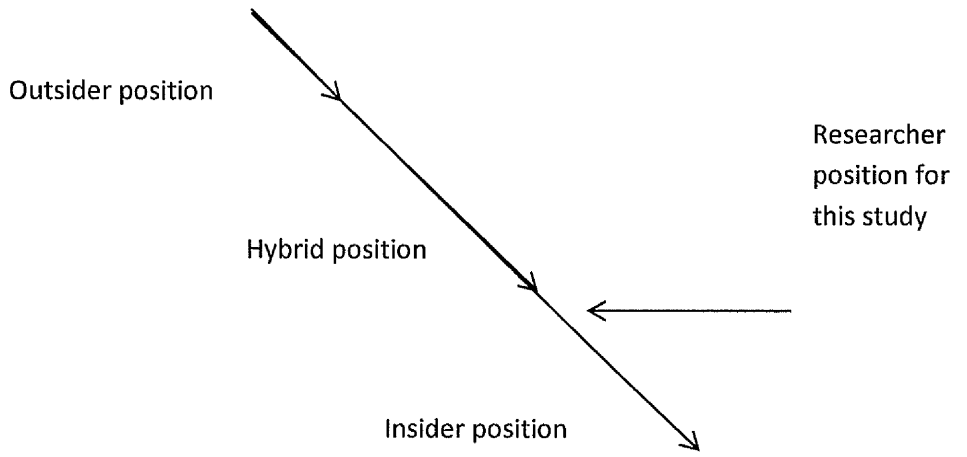

Figure 3: The researcher relationship with all aspects of the research, identifying the position of the researcher of this study adapted from McGhee, Marland & Atkinson (2007).

4.3.3 Ethical considerations

The principle based approach to conducting ethical research is the most commonly cited and most appropriate framework for judging the moral actions of the researcher (Tee & Lathlean, 2004). This is an approach to ethics that focuses on theories of the importance of general principles such as respect for autonomy, beneficence/non-maleficence, and justice. This is the approach taken by most ethical committees concerned with healthcare and is the case for this study.

Autonomy has been described by Hewitt (2007) as having the capacity to think, decide and act freely based on two conditions: the first is being free from controlling influences and the second is the capacity for intentional action. Autonomy in healthcare is applied as the notion of informed consent. Good practice in research specifies that all participants should be fully informed about the research project before they agree to take part. This is the notion of informed consent and is related to the ethical principle of fairness, which is the right of individuals to have sufficient information to make an informed decision as to whether to participate or not (Oliver, 2003). In both parts of the study a presentation was made to potential participants and on agreeing to be interviewed

they were provided with an information sheet (see appendix 2) prior to giving informed consent for the interview (see appendix 3). The information sheet identified the nature of the study and their involvement. Contact details for the researcher were available on the information sheet in order that questions could be answered prior to the interview. A consent form was also signed every time participants were interviewed.

One of the key features of the research process is that participants should be entitled to have their identity hidden in the research report, i.e. they remain anonymous (Oliver, 2003). Anonymity can be linked to confidentiality and is part of the informed consent process.

Anonymity during qualitative research brings challenges as the samples are generally small and it is often possible to link a series of events to an individual if the reader has some inside knowledge of the participants (Boman & Ronna, 2000). Care was taken to ensure that no reference was made participants' names or places of work in any part of the study that could lead to them being identified.

The principle of beneficence is an obligation to provide benefit to the participant and to balance that against any risks (Hewitt, 2007). Non-maleficence on the other hand means to do no harm, and to prevent and remove any existing harm. The interview in some respects could be seen to be therapeutic, offering an opportunity for catharsis with the associated benefits. During one of the interviews in the current study a participant stated that he rarely got the opportunity to explore his practice in such a way and found it therapeutic. On the other hand, if the information provided is sensitive and painful and not handled appropriately there could be potential harm. Tee and Lathlean (2004) suggested that the person centred skills required to develop a research relationship and maintain it are similar to those required for a therapeutic relationship: listening, attending to, summarising and reflecting back. The researcher was always very conscious of checking out participants' meanings by summarising and reflecting back aspects of the interview, in order to attend to what they were saying and that their meaning was clear. During the interviews participants were asked about situations that they

had found difficult and had left an impact on their practice. The researcher was very conscious that this could be harmful and was careful to endure that no damage was obvious before moving on. The interviews also ended on a positive note by exploring an aspect of practice that participants were proud of.

Some of the wider benefits are the impact of the outcome of the research. It is hoped that the outcome will either stimulate further research on the topic or impact positively on practitioner practice in the future.

There were some practical aspects to be taken into account in the context of beneficence, such as issues of liability and ensuring that both participant and researcher were fully covered by insurance. There were issues of data protection and how data would be stored and for how long once the study was completed, in order that participants' confidentiality was ensured.

The process of ethical approval via research ethics committees aims to make judgements about the ethics of the study before data collection commences, and it takes into account all aspects of beneficence and non-maleficence. Because of the theoretical sampling that was used during the study, it was necessary to achieve full ethical approval for each part of the study. Approval for the first part of the study was gained from the Wirral Research Ethics Committee in 2003 which incorporated local healthcare provider organisation approval. Ethical approval for the second part of the study was gained from the University within which the researcher works, the Cheshire North and West Research Ethics Committee and NHS Trust Approval to Proceed in 2007. The researcher entered into an honorary contract with the NHS healthcare provider organisation for the duration of the data collection. The relevant letters can be found as appendices 9, 10, 11 and 12 respectively.

4.4 Summary

This chapter presented an overview of the research methodology and theoretical framework that underpins the research study: constructivist grounded theory and structural anthropology with specific reference to the work of Levi-Strauss. The

research methods utilised and how they were applied within this study constituted the second section. This included a discussion on the population to be studied, access, how data was collected and analysed, and application to the research study.

CHAPTER 5

THE REAL WORLD OF PRACTICE CHANGE AND DEVELOPMENT

5.0 Introduction to the findings of the study

Following analysis of the data, four categories emerged which led to a Personal Process of Practice Change and Development that will comprise the final grounded theory. This term emerged as an in vivo code from participant 1 in the first part of the study, who used this term to describe the process of how practice changes. An in vivo code is one that arises from interviews and is a term special to the interviewee (Charmaz, 2006a, p. 50). Each category will be discussed in relation to the findings and relevant literature in a separate chapter (chapters 4, 5 and 6), and the final chapter of the findings will be the overall theory.

The tables below identify participants from the two sites and assign a code that will be used to orientate the reader when participant quotes are referred to.

Table 2: Study A, Nurse champions, participant coding

GENDER	ROLE	CODE
Male	Dialysis nurse	A1
Female	Primary care nurse, care of the elderly	A2
Female	Ophthalmology nurse	A3
Female	Dermatology manager	A4
Male	Care of the elderly manager	A5
Female	Care of the elderly manager	A6
Female	Primary nurse, hepatic disorders	A7
Female	Surgical pre-assessment nurse	A8

Table 3: Study B, parts a and b, Early intervention team (EIT), participant coding

GENDER	ROLE	CODE
Female	Manager	B1a, B2b
Female	Mental health practitioner	B2a, B2b
Male	Mental health practitioner	B3a, B3b
Male	Manager	B4a, B4b
Male	Mental health practitioner	B5a, B5b
Male	Mental health practitioner	B6a, B6b
Male	Mental health practitioner	B7a, B7b
Male	Mental health practitioner	B8a, B8b
Male	Manager	B9a, B9b
Female	Mental health practitioner	B10a, B10b
Male	Mental health practitioner	B11a, B11b

Generally when discussing the recipients of nursing care, the champions referred to patients, whereas some of the EIT members referred to clients and others patients; the term 'patients' therefore will be used throughout this study.

Participants referred to their change of nursing practice as both change and development. This term will be used throughout the study to describe change in practice.

5.1 The real world of practice change and development

The remainder of this chapter will explore how participants perceive and describe how their practice changes or develops over time. In addition the chapter will address how participants respond to change within their nursing practice, both changes that they have initiated and those that have been imposed on them, either from the organisation within which they work or as a result of national changes. An overall response to change will be identified that will incorporate resistance to change.

5.2 Hierarchy of practice change

Change, in the literature review, was identified as a process that results in the alteration or replacement of knowledge, skills, attitudes and styles of individuals or groups (Wright, 1998). Change can involve the discontinuation of past behaviours and the resulting perceptions, feelings and emotions that arise as a result of the change, and includes both the process and the outcome. This change can be top down or bottom up.

Participants were able to identify nursing practice that had changed and the factors contributing to that change. Figure 2 summarises how participants across both healthcare organisations identified that their practice changes. The categories were placed in a spiral to signify which were the most frequent and significant to participants. The spiral also highlights the fact that all aspects of practice change are interconnected.

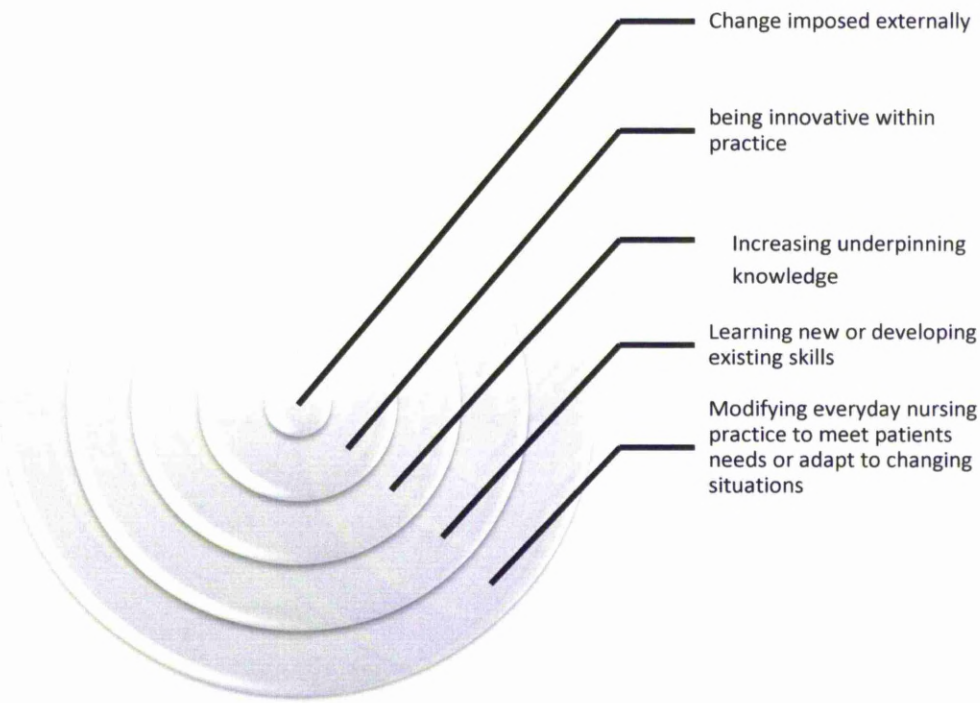

Figure 4: Hierarchy of practice change

Everyday practice changes are the modification or adaptation of practice, and are placed at the base of the spiral as this was identified by participants as the most significant type of change impacting on their professional practice. This type of

change was also the most highly valued and was seen as being the most influential. As part of the on-going interviews, participants were encouraged to highlight the changes that they felt were significant in changing their practice, and imposed change was discussed only by one participant in the mental health team. Due to the significance of this type of change a further interview with the mental health team was conducted to cover this aspect.

By far the most common changes to nursing practice identified by participants were the small day-to-day adaptations or modifications that were made in their everyday nursing practice in order to meet patient/client needs, or to adapt to an on-going or changing situation, as highlighted by the following excerpt:

> 'It's difficult to then switch that structured approach so sort of from a few clients of doing, having that experience where you've gone in and tried to deal with everything else, and then work on the CBT approaches for whatever problems they've got. It's very difficult to switch from being gentle, relaxed to structured and organised, so I guess that over the last year I've certainly shifted in that from the start I start in a not really organised regimented way with people, but I start off far more structured than I was doing, so from the assessment we set targets and we start to work towards those targets and there are times that you go off script and you have to deal with issues that arise. And not everybody is able to follow that and so you have to be a bit more flexible.' **(B1a)**

Patient/client compliance was a significant influence on practice change. Participants from both healthcare organisations discussed modifications that they made to their practice in order that patients would comply with the care provided. With the mental health team this involved adapting their approaches and interventions with clients according to their client's psychological state at that time. The following example is from one of the nurse champions:

> 'Within reason, because obviously if you're not going to put a little pressure on there is no reason in having a four layer compression bandages. You

might as well just put a little crepe on. You've got to try and get that balance between what is recommended and what is acceptable to the patient.' **(A4)**

The development of skills, both new and improved existing skills, was a further example of how practice changed for participants forms both healthcare organisations. This development of new skills was often referred to by participants as learning. The EIT was a new concept and members joined from a wide variety of backgrounds. Most of them identified new skills that they needed to learn in order to provide appropriate care. The following excerpt highlights this:

'Suppose I've had to develop my own skills with lone working, not going out to people's houses, not having other people there for opinions and advice, um I've had to develop my skills in completing assessments, because I spend a lot of my time doing that, and develop other areas like family work. I never used to do any family work where I was before. Our priority was to get them in, get them well and move them onto an acute ward, it was very, very, limited contact we had with the family. We do quite a lot of family work now, and the relapse prevention and long term goals. I never used to do anything like that.' **(B2a)**

Nursing takes place within a context of continual change and development. These changes include an increase in underpinning knowledge due to the increasing amount of available evidence and research, and examples of these include such technical developments as electronic patient records. Also knowledge about nursing practice is increasing as on-going research leads to evidence being produced over time. The following excerpt gives examples of how one participant viewed one basic nursing care procedure which has developed over time:

'I think aseptic technique is different to what it used to be. There is a lot more awareness of non-touch as well, which wasn't around when I was training. How you actually treat wounds and wound healing. I think that is general not just in dermatology. Pressure bandaging, that's another thing. At one time you just used to pad up the leg, now there is an actual process

to it. And taking Doppler's, you have to make sure there is a difference between them, if it's arterial or venous.' **(A4)**

An increase in the underpinning knowledge of practice was another area that participants identified as a part of practice change. The source of this knowledge arose either from their day-to-day experiences or programmes, courses or training events. The knowledge that came from their experiences was experiential knowledge and was highly valued. The following example highlights how the participants' knowledge has increased as a result of experience:

'It has developed and I think um, I suppose your knowledge really in what you are giving to patients, and the experience because I have been a gynae nurse of for years, so you can pass on a lot of that to the patients.' **(A8)**

The knowledge that is perceived to be gained from academic programmes and other courses is the theory or empirics; the science of nursing, the scientific principles, facts, laws and quantifiable evidence that underpin practice. This form of knowledge was valued by participants and was identified as developing in conjunction with practice.

'Yes, again really, through the course we are taught um, we've got our learning book. Say for example glaucoma we learnt all the different types of glaucoma and so as whereas we are taught why to put drops in, why not to put drops in, you know, particularly with glaucoma patients, this taught us you know the implications of putting drops in, can cause increasing pressure to the eye and that. Yes it definitely made us more aware about why we do these things and why we don't.' **(A3)**

Some nurses demonstrated innovative approaches to their practice, striving for continual learning and practice development to improve the quality of the nursing care that they provided to clients/patients. In some instances participants developed their own practice based tools from the experiences that they have had. The following excerpt highlights the development of an assessment tool that one nurse designed over a period of time:

'Um again because I've developed a kind of assessment as I've come along and I did have one of my own assessments, which I've kind of brought together from about three different sources. Um and then condensed it into something that, obviously assessment is continually on-going I don't think any of these care pathways would say that assessment's got to be done by the end of the first week. It just doesn't work like that because two months on and you realise that oh yeah you know didn't you know about that? You know, so I have amalgamated, um, I saw actually a very good assessment done by a nurse in some notes once and I thought it was so well laid out that I took a bit from that and a bit from um and early intervention team down in.... I think it was. They'd got a good set up so I've amalgamated it, um so I go out and I've got like, it is just bullet points um which might be on a regular assessment but I think it can lead on. I also developed a history sheet um which focuses on what's happened in the last two years. Um and the stresses, because people will say I'm ill now, I've got these symptoms you know, but then sometimes when you look back over the past two years and childhood stresses, you say oh yes I moved house or I spit up with the boyfriend or girlfriend, um yes and aunty died. But it didn't really affect me. But individually it didn't but collectively look you've had all these stresses in the last eighteen months.' **(B3a)**

Lastly there are the top down imposed changes, arising either from national bodies such as the Department of Health or the organisation within which participants work. These types of change were referred to least of all in the initial interviews, but were specifically targeted in the final interviews. Pardo and Fuentes (2003) identified typologies of change, with reference to organisational change. This typology could be viewed along a continuum starting with the low scope, incremental or evolutionary leading to high scope or strategic changes. Examples of imposed changes provided by the mental health team were mostly first order changes and examples included the implementation of electronic client records, and a new assessment tool. Only one participant identified a second order change and this was relocation due to closure of services as part of a change of government

policy. Participant's related that they had little control over these top down changes which at times left them feeling vulnerable. This lack of control is highlighted in the excerpt below where the participant is concerned about the increased accessibility of his client records and the resulting implications.

> 'It's your clinical case notes now 'cause I mean, I've been brought up in classical pen and paper you know and it was written you know and all my care plans everything was written up, where's everything's electronic now and suppose that's more available for everybody as in you had your care notes and they were yours but now they're everybody's. Everyone can access and look at what you done so I think that felt quite, ooh gosh, you know, what I write now everyone can see, you know, like before I wrote it and then perhaps a consultant would read it occasionally or vetted with the ward to see what are happy, every couple of years, but generally they were mine and suddenly they were everybody's and I think that felt a bit...I say threatening but it was a different scenario you know.' **(B7a)**

Several participants highlighted how they subsequently adapted their practice to take into account this imposed change. This adaptation can be viewed as a means of self-preservation. The following excerpt is how one nurse responds to the duplication of effort brought about by the use of electronic client records and the need to keep up with his workload.

> 'I think after a while you sort of, eventually, prepare tablets in your head, you know. If a person has got bipolar or psychosis or depression you have that sort of ready care plan in your head you know, that sort of standard one you know, and then you just adapt you know to the client's needs. You have that sort of one you put in quite quickly now, just comes like regurgitation really, which is unfortunate really, 'cause you do that 'cause its speed and easiness of the system really.' **(B3a)**

5.3 Response to practice change and development

In order to fully investigate nurses' perception of practice change and development, it is necessary to explore both how they perceive the change occurs, which was discussed previously in the chapter, and their response or approach to this change.

Participants were encouraged, as part of the interviews, to identify examples of when their practice changed or developed. Participants referred equally to both practice change and development in relation to their practice. The majority easily identified how practice changed and also the influencing factors. The majority of participants were positive about the changes that they had made to their practice and the influences on other colleagues, as highlighted by the following:

> 'I am proud of the unit, the staff that we have here and their attitudes to patients; there's always elements of good things but I think that they look at their practice more. I'm pleased with the Work Based and Integrative Studies (WIBIS) course; I'm pleased with the changes that we have made to practice; For example amalgamating day care and ultra violet light together and extending the hours without any more nursing resources. I'm proud of that.' **(A4)**

A model of the process of practice change and development will be developed over the remainder of the chapters. This model will take the form of a continuum that comments upon responses to change of practice, experience and the role of underpinning evidence that supports the change, and resistance to imposed change. Each of the identified aspects will be explored throughout the chapter and incorporated into the continuum, to build up a final model of participants' response to practice change and development that will be discussed as part of the overall theory in chapter 7.

The use of the continuum framework for this approach was based on the template used in a cognitive psychological theory. Cognitive continuum theory was developed by Hammond who investigated how judgement tasks or situations relate to cognition (Hammond, 1988). His research related to decision making in relation

to the complexity of the tasks involved, whereas this study looked at change and response to change. The decision to use a continuum was because it allows for the identification of opposite poles of investigation.

5.3.1 Self instigated change

Participants' approaches to change varied according to the type of change being implemented, whether the nurses were the instigators or the change was being imposed on them. The following diagram (figure 3) illustrates attitudes and motivation to change that they themselves have instigated. The diagram is in a series of steps and reflects their approach and where they seek evidence and support for the change. The diagram is based upon their level of motivation and the source of underpinning evidence that they seek to support the change. For ease of discussion, each category of change has been identified as an approach which will be assigned an overall name in the final discussion of the theory in Chapter 7.

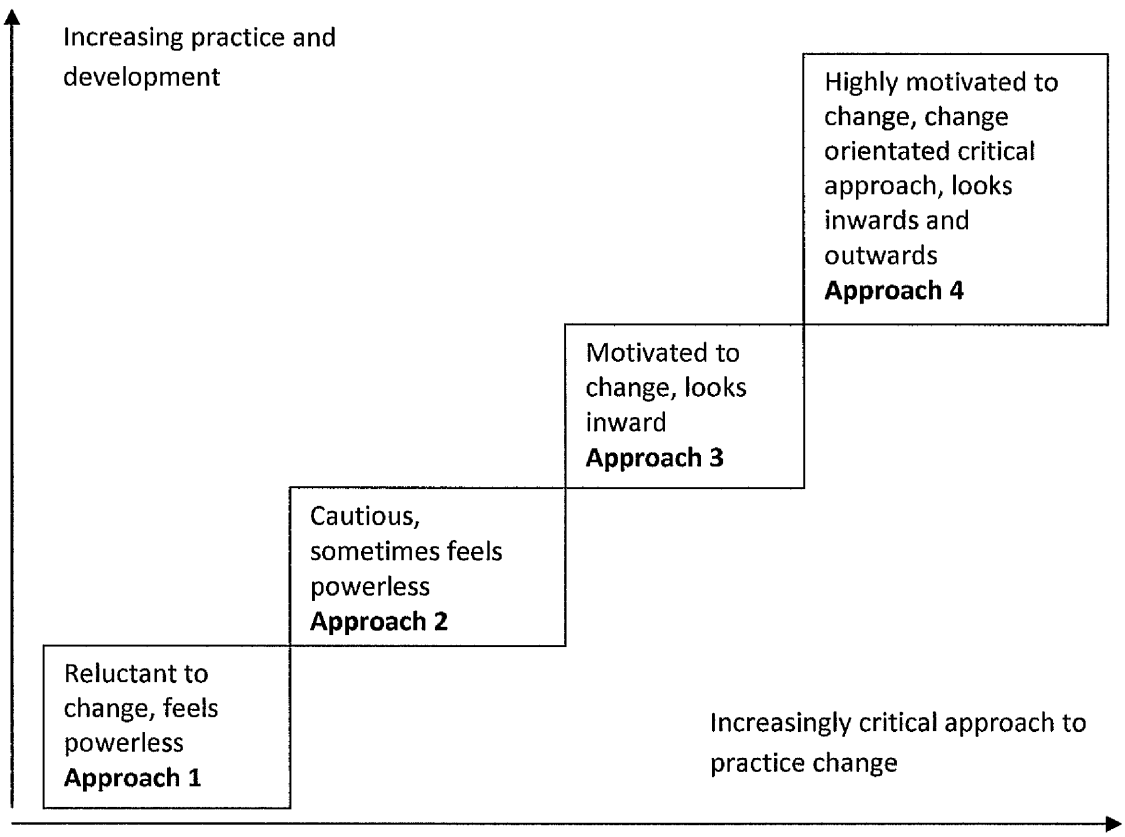

Figure 5: Response and characteristics of participants in their own initiation of practice change and development.

Participants who fell into the 'highly motivated to change, critical approach, looks inwards and outwards category', approach 4, were highly motivated and orientated to change and develop their practice. They took a critical approach to providing nursing care and actively looked for new and better ways of working. This involved seeking evidence from external studies, networks and benchmarking, and balancing this with what they had learnt from experience.

> 'Topical steroids, you are supposed to use fingertip measurements. Whereas we tend to put it on at high dose as needed all over and bring it down very quickly. Experience has shown us that if you just use fingertip measurements, you are not going to get anywhere. That is balanced against evidence. But obviously we bear in mind that you shouldn't use lots of it, and we only use it for short periods of time. Whilst we bear that in mind we adapt it.' **(A4)**

Only one participant from both healthcare organisations undertook any empirical research and this was small scale, related to nursing care within her own sphere of working, and was not externally or internally funded.

Participants within the 'motivated to change, looks inward' category, approach 3, took a critical approach to their practice and were highly motivated to provide effective nursing care. They instigated their own change in practice but did not routinely refer to external literature or benchmark against others, using experience and learning from others that they valued in practice, to make changes. Some participants relied on healthcare organisation practice guidelines or protocols as sources of evidence to guide their practice. The majority of the mental health team fitted into this category. The following excerpt from the champions highlights one participant's view:

> 'You can read up loads on pre-assessment if you want to, and you know you pick up a lot of things like that, but course wise there isn't a great deal out there and the ones I have been on haven't told me anything more than I don't already know.' **(A8)**

The third categories of response to change, approach 2, are those participants who are cautious and sometimes perceive themselves to be powerless. Participants within this category are less self-critical about their own care, and don't actively seek out or compare themselves or benchmark against others:

> 'To be honest I have thought about it recently and I am not sure who to talk to about it; somebody who deals with that element and the computer people. It is getting the chance to say – by the way who deals? But again once ward pressures start to instigate, you're tired, just wandering off home, you think oh I am going to have a quiet afternoon, I must phone and find out who can give me advice on this issue, then perhaps something will happen and you just forget. You become pressured and perhaps it might not become so important again, Ah you know I have been thinking about that, but like I have just said to you, again as you say I haven't changed it yet. I haven't delved there yet, given time and energy, for me personally anyway.' **(A1)**

The final category is 'reluctant to change and perceives themselves to be powerless in response to changing their practice', Approach 1. Participants in this category did not routinely question the care that they provide or what underpins their practice. Very often they relied on healthcare organisation guidelines to inform their practice and were reluctant to move away from what was familiar. This is illustrated by the following excerpt:

> 'For the dialysis patients a lot of it is (protocol driven). You have special central line care plans, protocols, for patients with like an infection there's a protocol for the line, what antibiotics to be given, where and when to track the bloods, there is a lot of protocol driven care on the wards.' **(A1)**

The higher up the continuum the participants were, the increasingly critical approach they took to nursing care, and the greater their practice change and development.

Seventeen out of the nineteen participants referred to this process of change in

practice as learning. 'Constantly learning', 'learning curves', 'learning on my feet', were the phrases most frequently used to describe the process of change that they underwent. This learning process did not always necessarily involve academic programmes, or training courses; participants described their learning from work and the experiences that they had as part of their everyday working life. Participants discussed learning in relation to the first four stages on the hierarchy of nursing change (figure 2): modifying everyday nursing to meet patients/clients' needs or adapt to changing situations; learning or developing new skills; increasing underpinning knowledge; and being innovative. The following excerpt highlights one participant's attitude to learning in the workplace, and was reflective of the attitude of the majority of both the nurse champions and members of the EIT:

> 'I am, I mean I've got young family but I am, I am always trying to kind of um look at new things. I think that is just part of my nature and I always want to, you know I think I've been constantly learning and constant student if I could be. That kind of thing, yes I enjoy the line of things. I'm kind of on the innovative side you know, even though I can plod along and do the job'. **(B3a)**

5.3.2 The theory behind the practice

Within the literature review, the perspective was put forward that there currently exists an emphasis both nationally and locally on promoting evidence based practice as a basis for underpinning nursing practice (McSherry, et al., 2006). All nursing practice has an underpinning knowledge base and this knowledge can range from experiential to empirical knowledge. There is a requirement, as part of the Code of Professional Conduct, for nurses to deliver care based on 'current evidence, best practice and where applicable, validated research' (Nursing and Midwifery Council, 2004, p. 10).

The reluctance to use research findings has been extensively researched (Easterbrooks, 1999; Larkin, et al., 2007; Kader Parahoo, 2000) and a summary was provided in the literature review. Previous sections of this chapter discussed nurses' response to change of practice and the findings included the degree of critical

thinking that nurses exhibited in their response to practice change. The final part of this chapter will build on these findings and explore the sources of practice knowledge that underpin this approach. This research highlighted that there is a continuum along which participants fell in relation to sources of practice knowledge that they accessed to underpin their everyday practice. This continuum is reflected in figure 4.

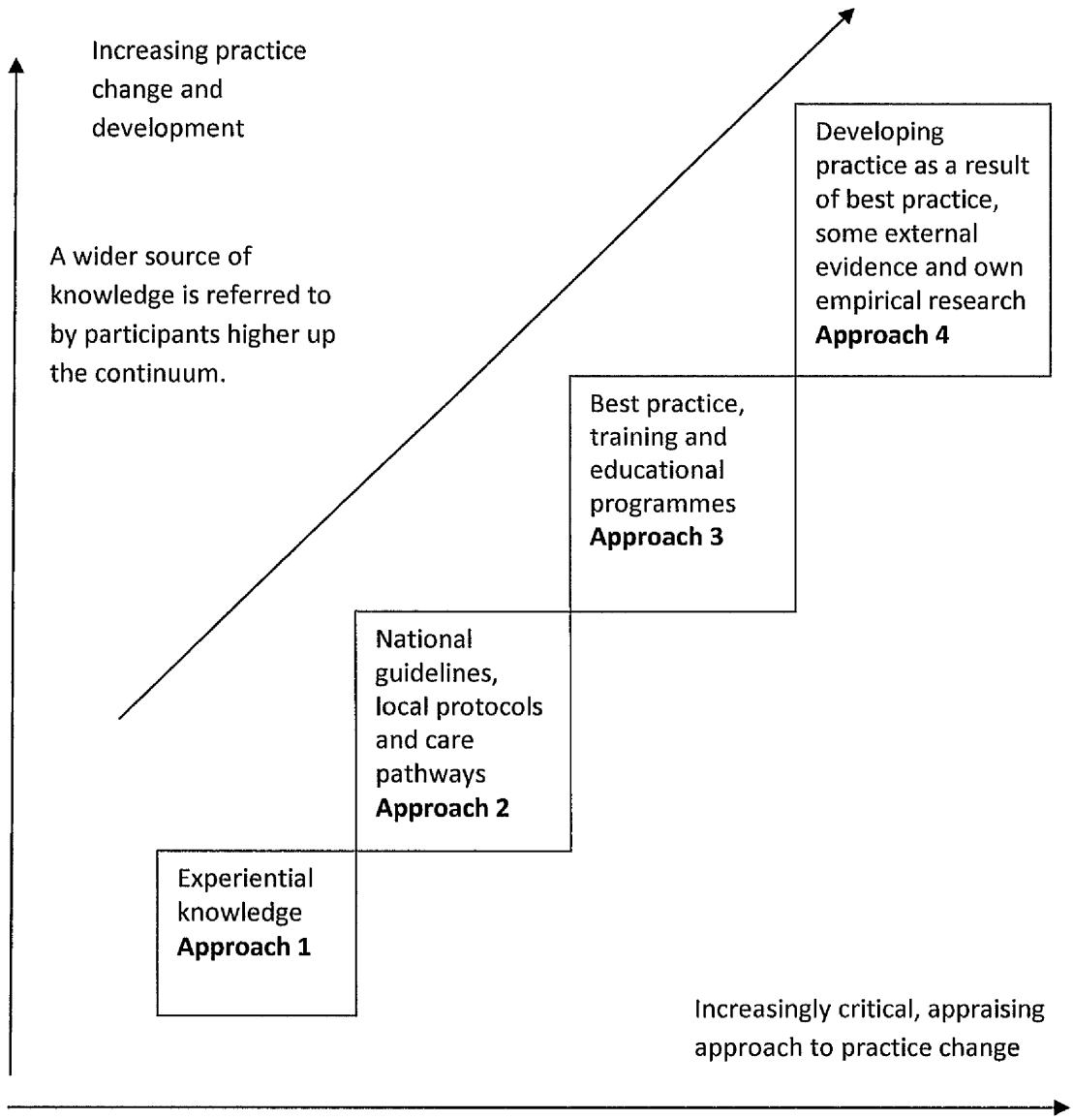

Figure 6: Sources of practice knowledge that participants used to underpin everyday nursing practice

As previously, the figure features a series of approaches within a continuum. Each approach identifies an additional source of practice knowledge that participants referred to as part of their practice change and development. Those at the top of

the continuum would access information from all of the previous stages of the continuum.

Some participants used only experiential or proximal knowledge (Winch, et al., 2005) as the basis for their practice and others used a range of the sources, as highlighted on the continuum. Participants in approach 1 relied for the most part on experiential knowledge gained from their day-to-day practice and gain empirical knowledge from other professionals within their sphere of responsibility, in order to fill in the gaps to enable them to practise successfully. The following excerpt highlights one participant who was anxious about the fact that she undertook minimal research into the underpinning theory of her nursing practice:

> 'Not particularly. I would say like research that to me is theory. I know really that when I am going home I should be going off to the library, to the computer, whatever. Perhaps putting things down, looking it up in a book, whatever. I don't do that.' **(A1)**

This participant relied heavily on experience and other colleagues to provide knowledge to fill in the gaps. Within the mental health team, clinical supervision was one mechanism through which participants gained experiential knowledge from their wiser supervisors:

> 'Used to have supervision, initially it was weekly and then after that it was like fortnightly or monthly. She used to review through your caseload and I saw her as, I didn't see her for management supervision, it was just clinical supervision. Looking at what I was doing with my clients, whether I needed to be seeing them as often as I was, and then because she had been in the services for a lot longer she'd say 'have you tried this or what about that?' That's something you just pick up as you've in the services for such a long time you just know what is out there for people.' **(B6a)**

Approach 2 was the knowledge that participants acquired from educational and training courses. These courses ranged from in-house training courses to programmes with academic credits attached. How much participants gained from

these courses depended upon how open minded they were to questioning their practice. The following participant values networking, comparing practices with others and going to conferences, and is open to practice change and development:

> 'I think every course that I go on initiates a change of some sort even if it is only a small amount. I would say every course makes you think about what you are doing, and modify or change your practice. I have done quite a lot of courses and they all have a little bit of that on them. Hopefully I will cascade that down to other people and see if they find it useful too.' **(A4)**

Some of the participants openly valued experiential knowledge over that gained from programmes and courses. The following participant is very experienced over many years, across a range of mental health specialities and reflects this view:

> 'Yes because that was a sort of, see when people talk about cognitive behavioural therapy (CBT) the early practitioners say well just try it. They weren't guarded and say no you know you can't do this because you're not qualified. They'd say, try this approach and try that approach, so you didn't have to go and get a degree, And so that's what you did. Yes and it fitted in well with what I was doing at the day hospital because things like anxiety management, social skills course and things like that were all sort of CBT based anyway. And we work a lot with people who were phobic at the time. So within that how, the way that it developed was really just trying it out and seeing how it went.' **(B11a)**

When participants who significantly valued experiential knowledge over other forms attended training and development courses, they were seen as opportunities to update their practice, not necessarily to change or develop it. Several participants suggested that their responsibilities were to share the knowledge that they gained, rather than use it to impact on their practice.

> 'Yes there was, there were a few things – certainly about the continence, the pads and things. In my mind I sort of knew those sorts of things and it was an update and it reiterated in my mind and they were like hot points,

oh yes, urge incontinence and I had forgotten about that. I think we need to do them for the rest of the staff as well. I enjoyed them; I like them not too technical, not too heavy. They were short, neat and easy to go through with. There was a lot of information in each short session. I felt that for me that was good and would help in my development. But my development might be compromised if I don't get the time or space for me to cascade this.' **(A1)**

Some participants saw training and educational programmes as the trigger for changing practice. The following excerpt highlights how one participant, following a dementia care programme, changed her practice and cascaded this practice down to others, including patients and relatives as well as other professionals:

'Um I worked in an EMI nursing course for 10 years and I must admit when I first went on my course, well I'll know a lot of it because I worked there, but a lot of it I just totally had forgotten and the two people who were training us were just fabulous 'wandering anymore', because they are walking for a purpose. I try and let the other staff know about this. We just sit in the resource room and have a little chat, especially if we have dementia patients in on the ward. Cos people do get het up and stuff and they are in their head, they are going off to work.' **(A7)**

Approach 3 on the continuum is the use of National Service Frameworks, protocols and care pathways. These frameworks could be nationally driven or local interpretations of national frameworks. The majority of participants from both healthcare organisations highlighted these as underpinning their practice. The following excerpt is taken from a participant who works in a pre-assessment clinic and adheres to National Institute for Clinical Excellence (NICE) guidelines on pre-assessment. These guidelines are however amended with local practice variations as the following excerpt highlights.

'The guidelines are laying out that everybody who attends for a general anaesthetic should have a pre-operative assessment, whether that be a face-to-face or telephone, the operation and their health. It gives you guidelines particular say, we are obviously just dealing with women, all

women over 40 having major surgery should have a full blood count. You don't follow that with all women over 40 because with gynaecological patients we tend to do that for most women regardless of age.' **(A8)**

NHS healthcare organisations take these guidelines and use them along with current evidence to develop protocols and care pathways for staff to follow. The following excerpt identifies how these protocols can provide participants with a process to follow, increases confidence, and acts as a means for standardising evidence based nursing practice across the healthcare organisation:

'Well I would say so, everything we do have a policy or a protocol to go with it. Yes I mean catheter, venflon, taking bloods, collecting bloods, setting up blood transfusion, everything is protocols. I would say it guides my practice a lot, because if you don't know how to do something or you are not one hundred per cent about what to do it, at least you've got these protocols and these policies as guidelines that we are all doing the same.' **(A1)**

Several participants from the acute healthcare organisation used guidelines, protocols and care pathways as their main source of knowledge to inform their and others' practice, whilst not referring to other types of practice knowledge. In some instances these protocols were used to resist change. The following example highlights how the nurse's practice was embedded into the protocol and change was resisted when the doctor wanted to change the protocol for one patient:

'We had a patient in who needed heparin, some of the doctors wanted to change the routine, off the protocol, the primary nurse was arguing with the registrar and saying what you want us to do is not on the protocol. If you want to do that you will have to document it, you can't just ring the ward up and say do this. I think we stayed with the protocol. He was not qualified enough to start changing charts.' **(A1)**

On the converse side, however, not all participants adhered to care pathways, valuing their own experiential knowledge over that of the pathway and not always following the practice as prescribed:

> 'I wouldn't say that I disagree with what's on the protocol but sometimes I think, the cannula; OK it's been in longer than it should be but its working well, its fine, its clean, there's no evidence of anything around it, it's spotless, the patient is comfortable with it. So why are we taking it out? Why do we have to take it out right at this minute just because the protocol says, if you understand what I mean? But then the protocols and policies and everything have been put there for a reason. We have to follow them as best as we can.' **(A7)**

Clinical audit is a key process underpinning the clinical governance framework and part of the quality assurance process in nursing. Audit is a well-documented process and can be described as a 'cycle of activity involving systematic review of practice, identification of problems, development of possible solutions, implementation of change, and then further review' (Currie, 2002, p. 607). The acute healthcare organisation particularly had a culture of audit use to identify and implement change in practice, and participants gave several examples of how audit had changed practice. One of the rationales for developing the role of champion in the acute healthcare organisation was as a result of a range of audits completed on attitudes to caring for elderly patients. The following excerpt describes how an audit influenced a change in practice:

> Right, we have just had one of our orthoptrists talking today about patients who DNA, (did not arrive), not arriving for their appointments. If there was any way of changing it so that we could persuade, well it is more the parents to bring the children in, because there is an awful lot of paediatric appointments not being attended. Since February we have brought in, well we did an audit and we did a questionnaire to 100 patients. They were asked – why did they think that patients did not arrive for their appointments. One of them was that appointments were given too far in advance and that was a real big thing. We asked the question – how do you think we could alleviate this? One of them was to phone up a couple of days before to remind them. Because the clerks are so busy we can't do that, we have our own workload and we can't do that. So I have brought a volunteer

in from PALS (patient liaison service) who comes in twice a week and phones up patients to remind them. And since that has been happening, we brought them in February, there has been a 10% increase attendance. So I am really quite pleased with that.... So that's a good change.' **(A3)**

Approach 4 on this continuum was where the participant sought established research to inform either existing or new practice that is being developed. In the excerpt below the healthcare organisation is implementing a new pain assessment scale. This was as a result of an audit of staff attitudes to and knowledge of pain management. This found that staff were unsure about pain relief in relation to patients with cognitive impairment and challenging behaviour; one of the pain control team actually completed an audit which showed that patients with cognitive impairment received less analgesia than those who didn't have cognitive impairment. As a result the pain sub-group designed a new pain assessment scoring system for use healthcare organisation wide. The acute healthcare organisation had a culture of using a range of multidisciplinary stakeholders in the development of new care pathways. When staff are involved in the development of new pathways there is more ownership and an increased chance that the pathway will be adhered to.

The excerpt below highlights the process that was undertaken:

'So, as part of this sub-group I have been heavily involved in trying to formulate a pain assessment scoring system and the documentation related to that. I feel really proud of that because we have involved anaesthetists, pharmacists, consultants, staff nurses, other nurse champions. We've developed this tool now and we are actually piloting it on a couple of wards now. We need a bit of time before we can evaluate it and that is what I am really proud of as I know it is going to impact on patient care in the future. We had groups set up and each of us said... I will look at facial expressions, pain scores, and things like that. Then we had a meeting and we discussed it, what we thought would probably be the best one. So we did that. I think Stirling was mentioned, because they do a lot of really good work up there.

> A lot of people researched it, one staff nurse gave me a really big wad of research on pain assessment tools, we all read it and we decided that we should be including this one as it looked the best one. Of course you don't know that until you pilot it. So we're hoping that it is going to prove really, really effective.' **(A5)**

At the top of the continuum, approach 4, were those nurses who undertook actual empirical research into practice that they influenced. The following excerpt refers to a small scale piece of research that was undertaken within the dermatology unit:

> 'The application of dithranol, that's been going since well before I was in dermatology. Dithranol, it's for psoriasis, it's from a tree. It burns good skin so our, actually no it has changed, but I was part of that change. We used to put the dithranol on the psoriasis to the plaque and you had to be careful not to put it on other skin. So when we put the dithranol, we used to talc them all over and put these stockinet things on. I used to end up with terrible chests, coughing the talcum powder all of the time. Imagine doing five or six patients a day, five days a week. It gets on your chest. So what we did was a study to see whether there was burning or smudging by not having the talcum powder, but just putting the stockinet on. It was an informal study that we did over a period of a month or something like that over several different patients. We found that there was no difference and so we got rid of the talc.' **(A4)**

These participants who undertook, or were involved in, empirical research were by far the smallest number within both healthcare organisations. The majority of participants relied on their own experiential knowledge along with the protocols and care pathways that their organisations prescribed. Again those who looked for evidence to back up their nursing practice were in the minority, along with those who used experiential knowledge.

5.3.3 Resistance to imposed change

Resistance to change in the literature review was identified as a response to change that is perceived as detrimental to the outcome of that change (Bovey & Hede, 2001b).

There was an observable difference between participants' responses to change in nursing practice that is imposed, and those where they have initiated the change or modification themselves. The main focus of participants' discussions on changes imposed on them was the implementation of electronic record keeping. Their responses to imposed change covered a continuum (figure 7) that ranged from those who took control of the change within their working lives to those who were overtly resistant.

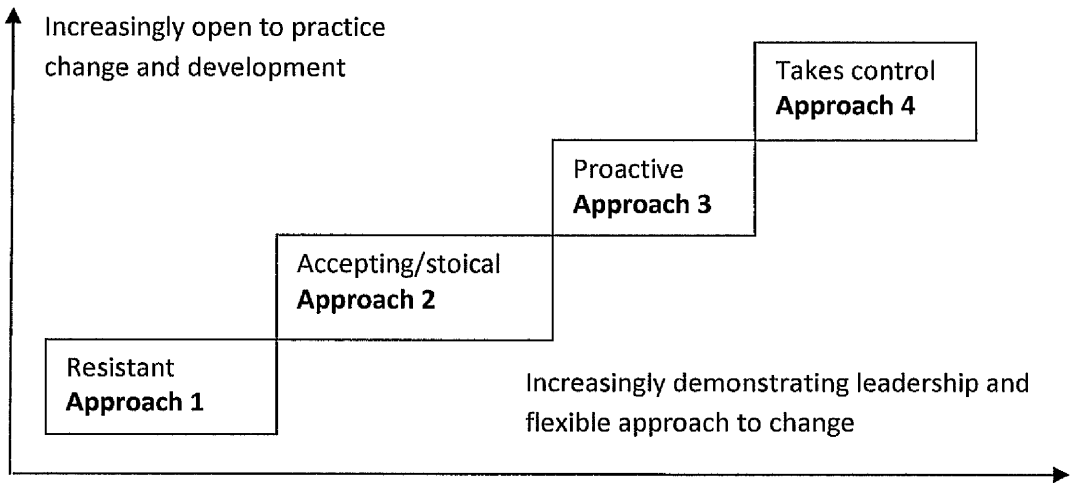

Figure 7: Participants' response to imposed changes in nursing practice

Four participants fell into approach 4, the category of taking control of the change. These were at management level, but not all managers interviewed fell into this category. These participants were expected to act as change agents within their departments and in response to this, they all developed clear strategies, ways of adapting the situation to meet both the healthcare organisation's and the team's needs. The following example highlights how one manager implemented a change that she thought would be unpopular to the team:

> 'Latest thing that came around was around recording every single violent incident of a person's past, regardless of whether it was violent or disturbed

behaviour, irrespective of whether it was related to mental health, but the system we've used is not an updatable system. Every time you do it you have to re-record everything. So you could have someone with a huge history of violence or sexual behaviours and every time you've got to re-record everything. Now, you understand why it's necessary to get a proper history and everything else but it's about the amount of time it takes and ways of doing that when you could be doing that every week. So what I've done is, I've done a two pronged thing, so constantly updating electronic notes system and changing formats and reports. So I've emailed to the relevant personnel who are involved in the electronic notes system and said this is a problem, this is gonna cause breaches in information blah blah blah. So I've done that side of things. I've got examples where information hasn't been recorded consistently from other areas and other incidents and other teams, and I've done a checklist for reviewing things on a regular basis and then with those memos to support A the checklist and B the checklist's support memos, I've then got those to then take to the team as part of a discussion and go how can we do this and make sure it's done but also recognise the amount of work it's gonna take them by trying to get it as an updatable programme rather than...yeah...so it's recognising the work it takes them, but also the responsibility that when it comes down as a memo it becomes policy moment.' **(B1b)**

Another strategy that participants used to implement top down change was adaptation of the new practice to suit their own needs. This can involve interpreting the guidelines in such a way that there is minimal change in what the team members have to do, or as one participant put it 'we played ball, but our game rather than theirs!' **(B1b)**:

'Everybody's now on a complex care plan and we do the standard, you know, the six items that we have to include and plus anything else we score or whatever, erm, and we've adopted so that as a team we have erm a weekly team meeting and we do a review of one individual a week. So they might be proper complex that we are reviewing and within that review we

look at the care plan and we do a review of the care plan and we do a review of the risk assessment and everything, erm, and we also gather bits of data for our own outcomes. But we use, for some of those people that only one practitioner sees, we use that as the team's opportunity to review their care as the CPA review. So that one person on their next visit can go out and do a review, maybe update a care plan with them based on comments that have come from the team's review the clients input. We do it that way rather than the very formal process of bringing everyone in, have a proper meeting, record it all, but we also have a record of that which then goes with the team minutes and if anyone questions it there is evidence that we have reviewed that care.' **(B1b)**

The majority of participants fell into the next category of being proactive, approach 3. These participants perceive themselves as not being able to take control of the situation that they were placed in as a result of the change, but could control their response by being proactive. In the following example the participant can see in which direction the team is heading and chooses to change role before the change finally happens:

'Yeah well it wasn't just the day...it was the day hospital in ... and then there was also the rehab house in... and that house had to be sold and they moved into the day hospital and they were going do our rehab reports and the clients we had in and then that changed so there was an awful lot of changes and erm it was about not knowing and everybody was saying we'll tell you next week, we'll tell you next week and people were worried about their jobs so it was quite a stressful time really. And I decided straight on that I thought I'm not staying around here, and I think it was probably like a rat leaving a sinking ship but I think at that point I thought I don't want, you know, it did become clear that you're gonna be a crisis team, you're gonna be working nights, out of hours, I had young children, well a young son the other two were a bit older but I thought I can't do that so I actually got a secondment then to a community mental health team just for six months and then this job came up here.' **(B10b)**

Participants using approach 2 on the continuum are stoical and accepting of the changes. They complained about the change, and the impact on themselves, but accept and put up with the perceived imperfect systems. Two participants fell into this category:

> 'Some days I say yeah I would, I don't know, it's probably 50/50 in some ways. Yeah. Some days I'd probably say it's 70/30 to the electronic system. It's just that it's so time consuming. I think that's what...it's difficult to keep on top and keep up to date all the time.' **(B3b)**

Five of the participants fell into the category of resistant to change in relation to the implementation of top down change, approach 1. For all of these participants, a contributing factor is the feeling of being powerless, not supported by management as highlighted by the following:

> 'At the time I felt...I guess I did feel disempowered. I felt let down because of the people that told me that this was going to happen even though some people had said "Oh no, no, no, it won't happen, you'll have more choice in this." But I had absolutely no choice. Previous general manager who had recruited me to the job, also, before I'd even moved up here had said to me please try and draw up a job description for this consultant. So one assumes that if you are drawing the job description up you might be involved in the recruitment process but that went by the by. I think this general manager had tried to be involved in working with doctors in that respect and...I felt like, you know, more of just the same. I felt detached from it. I felt like I didn't have any control. I didn't have any say. I wasn't respected. And it's been borne out and proved to be the case in that sometimes these people don't necessarily see me as the team manager, and in fact some doctors particularly can consider themselves to be above laws, and they just consider themselves to be you know, do what they want and then it just doesn't fit in with the concept of team working. How can the team work when everybody's not working to...? And certainly the most well paid, possibly influential member of that team is so distant and detached.' **(B4b)**

All three participants in this category discussed attempting to stand up to perceived management pressure and the resulting stresses that they felt, as highlighted by the incident below:

> 'Right, well, I was told by a senior manager that I should smooth things over really. The transition of the staff, and they wanted to cherry pick who they wanted for this service and then didn't do it by interview. That sort of not looking at the staff's...their rights really. And I had a decision to make about whether I was going to be corporate and do as I was told or be... really looking after my colleagues and I chose the latter. I got the union involved and as a result I was sort of...my options were then reduced.' **(B11b)**

5.4 Summary

This chapter has explored how participants perceive that their practice changes over time, and found that this change can be described as a Hierarchy of Practice Change and Development. At the bottom of the hierarchy are changes initiated by participants themselves and seen as the most significant. Changes at the top of the hierarchy are seen as the least significant to participants, and are imposed by external bodies such as the organisation that they work in, or professional or national bodies.

Responses to these two types of change were investigated and an overall Practice Change and Development: Response to Change Continuum was identified (see figure 6); this final diagram in this chapter collates both responses to change and the sources of knowledge that guide practice.

At the top of the continuum, approach 4, participants exhibit more control in relation to changing their practice. They actively seek out evidence, and are open to using networking and new ideas, including small scale research. These participants are highly motivated and take control of situations, turning them to their own advantage. These individuals were in the minority within both healthcare organisations.

Users of approach 3 are those participants who are motivated to change and develop their practice, but tend to use evidence in a more limited way. They refer to best practice of others that they see and experience, using knowledge gained from training and educational programmes. These individuals can be proactive to imposed change, turning it to their advantage.

Participants using approach 2 are those who rely mostly on the controls set by the healthcare organisation that they work in, which include audit, national guidelines, local protocols and care pathways. These individuals take a cautious approach to change and can feel powerless at times. They tend to be accepting of imposed change and take a stoical approach, complaining but getting on with it.

In approach 1, the bottom of the continuum, participants routinely do not seek out or use external sources of evidence, or completely comply with their organisation's protocols, local guidelines or care pathways; they rely significantly on experiential knowledge to guide their practice. These participants are generally reluctant and resistant to change.

The higher up the continuum, the more practice changes and develops as a result of leadership, flexibility, and an increasingly critical approach to practice change and development.

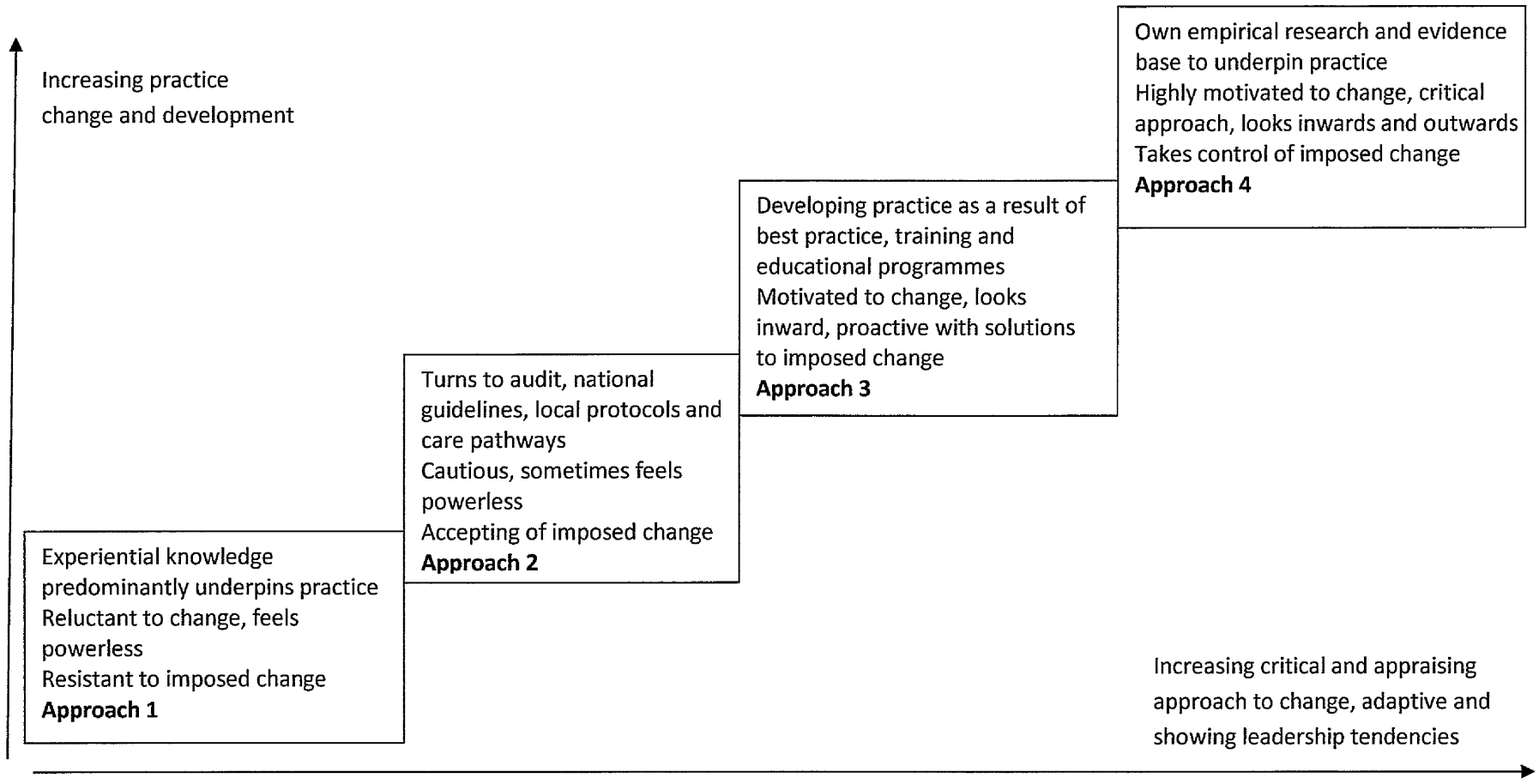

Figure 8: Practice change and development: response to change continuum

CHAPTER 6

EXPERIENCING PRACTICE

6.0 Experience in practice

Chapters five and six will discuss the process of practice change and development that emerged from analysis of the data. The overall process is referred to as participants' 'personal process of practice change and development', which was an in vivo code that one participant used to identify her process of practice change and has been adopted within this study.

In this study participants identified that clinical experience is the cornerstone of their working lives. The majority of participants interviewed identified this experience as the one overwhelming feature that impacted on their practice, and it was the most significant influence on how they functioned on a day-to-day basis. The role and nature of experience *in nursing* has not been well documented, with only three available references that directly relate to the nature of nursing experience (Arbon, 2004; Radwin, 1998; Watson, 1991). Numerous references are available, however, that relate to the role of experience in the process of reflection (Brannigan & Moores, 2009; Johns, 2009) and experiential learning (Mezirow, 1998; Miettinen, 2000).

This chapter will explore the nature of experiences that participants in the study identified as impacting on their practice and leading to some sort of change or development. The majority of participants were 'experienced nurses'. Becoming experienced as a nurse can be defined as 'a progressive and continuous interaction between experience, meaning and the lived world resulting in a personal and unique understanding of practice' (Arbon, 2004). Being experienced does not necessarily lead to becoming an expert or to superior performance. A 'ten year rule' identifies this period as the accepted minimum amount of experience necessary to master complex skills and become an expert (Ericsson, Charness, Feltovich, & Hoffman, 2006). An expert, according to Benner (2004), is an individual who does not need to use rules to guide performance but has developed the ability to act effectively using intuition or multiple cognitive processing; in other words, has

developed the ability to think several things simultaneously and make a quick and sound judgement.

This chapter will also explore how being experienced impacts on participants' practice change and development. As in the previous chapter, a continuum will be identified that builds upon how nurses respond to change of practice and the sources of knowledge that they access to underpin their everyday working life. The experiences that nurses have and how they interpret them are influenced by their own personal and professional values, so this chapter will also explore the participants' personal and professional values, and how they impact on practice change and development.

6.1 The nature of experience in practice

Watson, in an early study, analysed the concept of experience for nurses, which was defined as 'the exposure of people to situations and the development of their skills and knowledge as a result of this exposure' (Watson, 1991, p. 1117). The majority of the experiences that participants discussed as impacting on their practice were situations that they found themselves in as part of their everyday working life. The experiences that participants recounted initiated strong emotions, either positive or negative, and were for the most part linked to patient or client care. The positive experiences usually reinforced personal and professional nursing values. Negative situations could cause them distress or make them feel uncomfortable and see the need for change. The experiences could be one-offs or on-going. Moon (2004), in work on experiential learning, suggests that experiences that lead to learning are specific, and happen at the right time and the right place for the individual, and that some are more effective than others. The most effective experiences are those which challenge the individual when existing knowledge or skills are inadequate. The majority of participants recounted experiences that they had no control over and were not expecting to occur.

Participants identified positive experiences that can lead to change. The following example is an on-going situation in which the participant is well supported, her actions are positively reinforced, and she is aware that her practice is changing and

developing. She also knows that she has support.

> 'I've been there an ophthalmic trained nurse since February, so up until February I didn't do it. I did training towards it, you know. I was in with an ophthalmic trained nurse. It's only been since February that I have been, so it's fairly recent. I really like going on the phone actually. Um, especially if I have helped that patient, you know and answered a query, and they don't have to come in because they go to their own optician or they go to the chemist and get. It's rewarding and that's refreshing. It's also interesting when I do get a patient who needs to be seen in primary care to. I mean say for example it's the morning and I bring them in for the afternoon. It's nice to follow that patient through, particularly what's been done for that patient. Yes, well yes. Because I am getting more confidant as I am going along. There is always somebody you know, such as our primary care specialist nurse. If there was ever a query if I wasn't sure about anything, I would either go to him or a doctor. So I know that I am not on my own, but as I have become, when I first started I was in and out like a fiddler's elbow. Whereas now you know I am more confident at what I am saying. On reflection you know, when I put the phone down and I say yes I am happy with that.' **(A3)**

Both the champions and members of the EITs identified situations that were distressing and had impacted on their future practice. For the mental health team this included several incidents of clients committing suicide. The following is one example:

> '...Background to that was difficult because I had actually been away for three weeks, I'd been on annual leave, and come back for one day and sent on a course for one day and then come back and he had actually hung himself that morning. He was a young man who had got huge psychological issues and a diagnosis of anti-social personality disorder. Um and I know it sounds awful but I think had worn staff down to their limits and so had, you know he didn't get the most, he wasn't, he was one of the 'unpopular

patients' um and he'd been re-diagnosed, this is going back a few years now and anti-social personality disorder, or psychopathic disorder and he was really upset by that. Really upset, because he saw that as being negative, with comments about him personally and afterwards because he'd written all these Royal College of Psychiatry, you know the suicide report reforms he had actually written to his father and basically sent a suicide note to his father saying goodbye and sorry and all the rest of it. No one had picked up on it because his father had rung the ward and said you know I've received this from him, and no one had actually picked up on it.' **(B1a)**

Participants related that incidents like these make them question the effectiveness of their interaction with the client. The outcomes of the ensuing review process initiated by the healthcare provider following this incident increased their self-awareness and altered the way that they approach clients in the future. The following excerpt identifies how the above participant changed their approach after the incident.

'I don't feel at all afraid to ask people about their intent to or thoughts about harming themselves or other people. I've no qualms about asking people that. I know a lot of people shy away from asking those questions, but I don't. I always ask people. I know risk management's high on everyone's agenda but I haven't been overly protective either so. I know other people who you just didn't see it coming, not that I was involved with so directly, but other people you really wouldn't have thought would have committed suicide and have done so you can't sort of stop every bad thing happening, um but also if you ask people and talk to people about that.' **(B1a)**

First hand experiences were common themes that participants from the mental health team discussed as having a significant impact on their practice. Participants discussed the experiences that they had of either having had mental illness themselves, or having a close relative who has experienced the mental health services over a period of time. This first-hand experience afforded insight and empathy into the nature of mental health illness and the challenges of accessing

services, which in turn impacted on their practice. None of the participants from the acute healthcare provider, however, referred to any similar first hand experiences. The excerpt below identifies one of the participants discussing his brother who had experienced mental health problems:

> 'What he's going through, it makes me more passionate about my job. Um and I think not only have I got a professional understanding and experience and knowledge about the specialised area but I've also got hands on experience. It's not just a job to me. I have been where these other people are now; I've experienced what families are experiencing. I've lived with someone who's experiencing psychotic symptoms, quite paranoid in nature, and the delusions, and the experience of hallucinations. I know how it can affect a family, so, I think it's quite positive really. Obviously I'd change it, but I do, I think it works well in a way that I can relate with people, it's not just come from a text book. I have experienced it as a first hand myself.' **(B4a)**

Repeating similar experiences can impact on the participants' level of skills development. Participants related how having repeated experiences reinforced and increased their level of skills. Participants from both healthcare provider organisations were able to identify how repeated experiences increase the effectiveness of their practice; the example below is taken from one participant from the acute healthcare provider organisation. The mental health team related this principle to developing the ability to engage clients.

> 'Certainly in the case of pressure areas, the more you see the more you can identify. Perhaps even quicker at being able to designate and delegate and you know, even the prevention side of things, you can almost forecast, when you are more experienced to do that. I certainly feel more adept at that side of things.' **(A1)**

Research by Radwin (1998) supports these findings and suggests that a nurse's practice over time provides opportunities for repetition with regards to patient scenarios. Knowledge therefore develops as a result of the sequence of events, before, during, and after each situation. Subsequent situations are no longer

unique, and provide the nurse with the opportunity to compare and contrast knowledge and outcomes of previous events with the present.

Several of the participants from both the acute and the mental healthcare provider organisation discussed how their development was facilitated by being provided with a range of experiences and structured support within the workplace. The example below identifies how a ward manager strengthens the role of primary nurses by facilitating a range of experiences to improve their skills, supporting them and delineating their boundaries with other grades that they work with. This strategy can be identified as coaching: working with a mentor who facilitates a range of experiences for the mentee who then learns and develops through experiential learning (Davis, Middaugh, & Davis, 2008).

> 'I've given the primary nurses a lot more responsibility because I have found that primary nurses weren't really happy within their role, basically because they didn't really have that support in the past. There wasn't a barrier if you like. The primary nurses, associate nurses and healthcare assistants all didn't seem to be any barrier between the grades. They all became really quite friendly and things did suffer, it did have an impact. So now what I have been doing is to get the primary nurses to take on more of a role, that they now take responsibility for managing training, they hold ward meetings now. We have days, I call them medical device alerts, they have those to do. They do the off duty; they do a lot more hands on managerial things. I have given them study days with me so that they can see what I do with all the administration with the wages, the budgets and things like that. I get them involved in interviewing new staff as well. So they have a lot more responsibility now and the actual work and the relationships are better. Each grade is starting to respect each other.' **(A5)**

Participants from both healthcare provider organisations identified incidents where their organisations implemented practices that led to difficult situations for them to deal with. The example below refers to the provision of a leaflet to patients prior to an investigation detailing all the possible side effects of one drug that is

administered during an investigation. This practice results in patients arriving in the clinic in a very nervous state, resulting in the nurse having to spend time calming the patient before doing the investigation. This practice is a result of nursing and medicine moving towards a more honest and truthful disclosure to their patients. It is based upon the value of truth-telling and is seen as desirable (Tuckett, 2004). The following example highlights this issue:

> 'Well for example, fluoroscein clinics. I mean we go through what the patient expects, you know, what the patient needs to know to expect whilst we are actually doing the procedure. So the first half hour would be explaining the procedure to the patient, making the patient feel comfortable. We do give an information leaflet to the patient prior to coming for this procedure. Because it has to list possible side effects of the fluoroscein, a drug that we give as a bolus injection by cannula, you know patients are already worried that the, fortunately it's extremely rare, but we have to mention the possibility of anaphylactic shock. A patient just reading that in the information leaflet, you know they are already worried about it. You know they don't want the injection that might send them into anaphylactic shock. It's just a case of talking to them, well you know it is extremely rare, we are talking about 1 in 150,000. So it's basically getting them more relaxed. Normally by the time that we are ready to start the procedure, you know they are fine. It only takes 10 minutes you know to talk to patients and explain. They come in with a blood pressure of ... We have to give them a cup of tea, reassure them, and hopefully by the end of the cup of tea their blood pressure has gone down.' **(A3)**

The mental health team identified similar situations that caused them distress. One example was the move over to a risk assessment tool, undertaken in order to standardise paperwork across the healthcare provider organisation. Participants felt that this assessment was not fit for purpose, taking into account their specialist services, and was putting their practice at risk as they could not fully document all that was needed. Should there be any incidents, followed by formal reviews, they

felt that their records would be insufficient for the evidence required, placing some of the blame on them.

6.2 Being experienced

The majority of participants across both healthcare organisations were experienced nurses. Most of the champions who participated in the study had been qualified for over ten years. The majority of the participants interviewed from the EIT were at Band 6 or above on the Agenda for Change Scale, which is nurse specialist level, and needed previous experience of other mental health services in order to be in the team.

Experience for the participants meant having an existing core of skills and knowledge related to the nursing care which they take from area to area. The EIT was a new service that had been set up and the team members had no previous experience of working within this field. They all brought with them existing expertise which was sufficient in the first instance, but needed refocusing as they developed the role over time. These findings concurred with the research undertaken by Arbon (2004) who found that being experienced in nursing is characterised by the acquisition of knowledge and skills that have arisen from experience, and which are portable and not diminished significantly in differing contexts.

As experienced nurses, participants valued and expected to share their expertise and knowledge with colleagues. This sharing took the form of contributing to the development of guidelines for care, teaching sessions for students, writing work based learning modules for qualified staff to gain academic credits, or even just being able to answer questions from juniors:

> 'If there is something that I don't know, a syndrome or somebody has come in with something that I don't know about and because I am more senior now, I feel that it is my duty to find out about that particular procedure or syndrome or whatever, condition. Because if somebody more junior asks me about it then I feel as if I should know.' **(A3)**

With experience, the majority of participants' nursing care, from both healthcare organisations, became more patient or client centred. This concurs with Radwin (1998) whose research into experienced nurses suggested the nurse was more likely to focus on the patient in a given situation, rather than on equipment, technical factors, or others' priorities. The informants related that, as experience accrued, they became less centred on their needs and more focused on what the patients need. The following example is a very experienced nurse who adapts her care to take into account what the patient will accept:

> 'Again it just underpins everything I do, everything I do I think about, I try to think about it from the client's perspective. And if I don't understand it, I will ask. And we do anyway in this team. We have like service user groups and we get people together to ask them what they want from us, what we're doing. We're new at this too; you help us understand what would be better for you. Um so that is a more systems thing, but the way it works with me individually, it's just again promoting positive kind outlook on things and not that kind of just straight into old ways of thinking. So specifically it just underpins.' **(B8a)**

Participants as they became more experienced developed more confidence in the knowledge and skills that they acquired from experience. With this confidence, the nurse would deliver interventions that were a result of balancing an acknowledged evidence base with their knowledge from substantial experience in practice. The excerpt below is an example of this. The experiential knowledge in his instance has taken priority over the evidence base and the practice adapted accordingly.

> 'Let me give you an example, potassium permanganate, it has been shown that with repeated use it is carcinogenic. It is one of the best things that you can use for an exudating wound. We are probably a bit more mindful of using potassium permanganate; we don't use it any longer than necessary. We don't steep them in big baths and leave them for an hour, like we used to do. We get blistering conditions where we put people in potassium permanganate baths. We used to bung in a couple of tablets, but now we

measure the amounts so that the dilution is correct. Whereas before we might not have and they would turn out deep purple, now we do it rose pink. So it is modified.' **(A4)**

One feature of the experienced individual is that they perform tasks almost subconsciously and are able to retrieve information quickly without having to apply rules. This sense of 'being experienced' and not having to think about performance can lead to the individual being overconfident when undertaking routine procedures, which might lead to unintended behaviours or mistakes (Redman, 2008). The example below is of an ophthalmology nurse thinking of what she would do outside her work whilst giving information to a patient.

> 'I've only just started doing pre-assessment for a couple of months really but talking to K and S who do pre-assessment on a day-to-day basis, they go through everything, ask all of the medical history and everything else. Do biometries, but then they explain to the patient what they should expect going up to the ward. I think it was ... who actually said she can be going through it parrot fashion and then as soon as somebody stops her and asks her a question, she has to stop and think where she was. She said, she said she could actually plan what she is having for tea tonight, but she says it so often.' **(A3)**

6.3 The continuum of experience and development of practice

As in the previous chapter, data analysis revealed that participants could be described along a continuum of how they use experience to contribute to practice change and development. This use of experience is balanced against other factors that influence practice. The continuum is described in figure 7 below and as previously each approach is assigned a number.

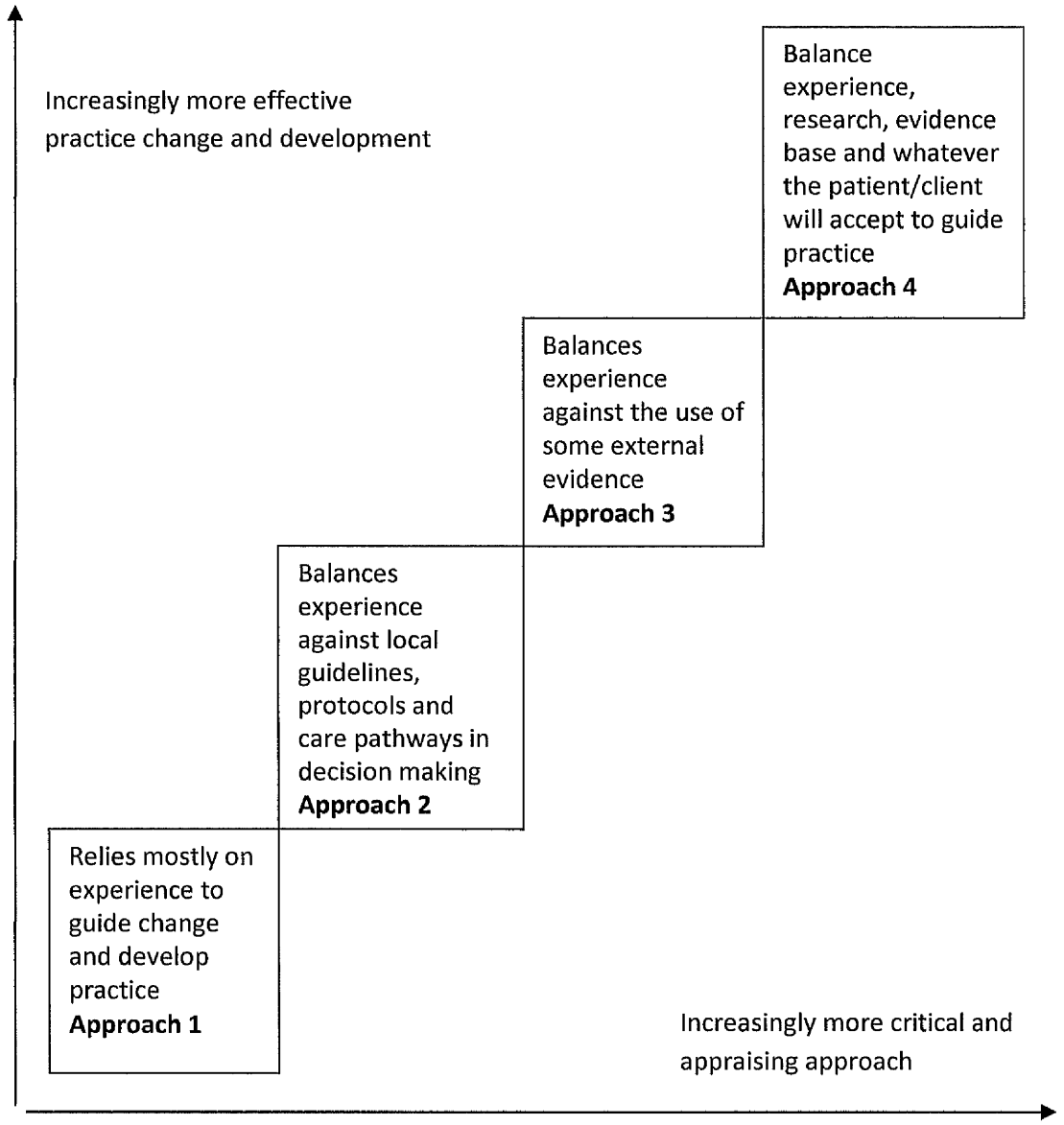

Figure 9: Practice change and development continuum: The role of experience

Nurses using approach 1 of the continuum rely mostly on experience to adapt and modify their practice. They very rarely consulted related external evidence, and examples could be identified from both the acute healthcare provider and the mental health team.

> 'I would say yes in the instance of experience that I can bring it all down to experience. That perhaps I can recognise things more easily, I can identify

things more easily. I don't know if that involves really the role of change, or whether it is just my experience?' **(A1)**

A core of nurses use approach 2, predominantly using experience to back up practice and balancing this against local expectations of the healthcare provider to follow local guidelines, protocols and care pathways. In this category, the use of experience is less prominent than in approach 1, though sometimes the guidelines are ignored in favour of the participant's experience. In the following excerpt, the participant values benchmarking for the sake of it, regardless of the fact that it might not be the most appropriate area to benchmark themselves against:

'Benchmarking myself against another ward, an acute ward, I come from an acute setting, and although it's a different type of patient (care of the elderly), I think it is better that we benchmark ourselves against each other, and if they've got a good practice I would ask them to share it. And if there is something that they are not aware of, you know share the information.' **(A6)**

Users at the third stage of the continuum, approach 3, are participants who predominantly use experience to guide practice, but will at times seek external evidence such as published studies or other good practice in other organisations. The following example highlights the development of a protocol:

'Yes they did, I think Stirling was mentioned, because they do a lot of really good work up there. A lot of people researched it, one staff nurse gave me a really big wad of research on pain assessment tools, we all read it and we decided that we should be including this one as it looked the best one. Of course you don't know that until you pilot it. So we are hoping that it is going to prove really, really, effective.' **(A5)**

At the top of the continuum (approach 4) is the person who balances experience in practice against published evidence or good practice elsewhere, and takes the patient/clients' needs into account. There is least reliance on experience and a more critical approach to practice change and development.

'Let me give you an example, topical steroids, you are supposed to use fingertip measurements. Whereas we tend to put it on at high dose as needed all over and bring it down very quickly. Experience has shown us that if you just use fingertip measurements, you are not going to get anywhere. That is balanced against evidence. But obviously we bear in mind that you shouldn't use lots of it, and we only use it for short periods of time. Whilst we bear that in mind we adapt it.' **(A4)**

6.4 Personal values and nursing practice

There are several influences on nursing practice and Rassin (2008) suggests that although nurses' experience plays a significant part in their development of practice, other non-nursing aspects of their lives also impact significantly on practice in terms of understanding who they are and what is important to them, which in turn impacts on the development of their practice. These non-nursing experiences include their own personal values. The majority of participants within the mental health team were able to identify both specific nursing and personal values and how they impacted on their practice. The most frequently cited values were being patient/client centred, empathy, caring, respect and altruism. There can also be conflict between the values that participants hold, the values of their organisation and their professional values.

A value is a belief or attitude that is considered desirable by the individual and they form the basis of the individual's actions (Skott & Lundgren, 2006). They are standards that define social and professional behaviour and have an impact on moral judgements. Values are organised hierarchically into a values system according to the individual's priorities, and provide a standard for living and form the basis of many of the individual's opinions in life (Rokeach, 1973). Values can influence perceptions and guide behaviour (Aroskar, 1995), and are developed from the individual's cultural environment, social groups, education and past experience (Rassin, 2008). Professional values provide a common framework for action and expectation or standards for the profession. They also provide a framework to evaluate the integrity of the individual and the organisation (Weis & Schank, 2002).

The values, attitudes and beliefs that are acquired by nurses are the result of interaction with personal beliefs and the effects of experiences gained through initial educational preparation, along with professional practice values and beliefs (Till, 2007).

There has been extensive research undertaken on the nature of nursing values resulting in the following being identified as prevailing today: aesthetics, altruism, equality, freedom, human dignity and justice (Altun, 2002; Rassin, 2008). Aesthetics which are the qualities of objects, events and persons that provide satisfaction, embraces personal qualities such as imagination, appreciation, sensitivity and creativity, and attitudes and personal qualities such as caring, kindness and self-discipline (Altun, 2002). These aesthetics are related to the art of nursing which includes values and a commitment to holism (Ryan, 2004). Being relationship centred is also one of the attributes of aesthetics in nursing (Lindeman, 1999) and this is the most frequently cited value reflected by the mental health team. Those who have these qualities adapt the environment so that it is pleasing to clients and create a pleasant work environment for themselves and others; they present themselves in a manner that promotes a positive image of nursing (Pask, 2003). The following excerpt highlights this value clearly:

> 'I also want, depending on funding, is to have some more activity workers who will set up, because.... is seen as quite a wealthy, affluent area, you don't get the resources thrown in, so in terms of groups and activities for people to actually join in with, they are few and far between. A lot of our younger ones, late teens and early 20s have lost their friends, their social networks, and they are fairly isolated. It's really difficult, you can't create groups of friends for people, and you can do all sorts of things but not that. So what we wanted to do to be able to set up things like five a side football evenings, so that people can go and play football together and meet people. Plus the research shows that when you are doing something like that you feel better about yourself, your physical health improves, experiences of hallucinations reduces, all that stuff, so there's loads of health benefits as

well as social benefits. So we want a worker on a budget to just focus on developing social activities, that sort of thing.' **(B1a)**

Altruism, which is regard for the welfare of others, includes such personal qualities as caring, commitment, compassion, generosity, perseverance, benevolence and sympathy (Altun, 2002). This value was very apparent from participants from both the acute healthcare provider and the mental health team. The following excerpt highlights this value:

> 'A value about caring for other people, value of life, in terms of keeping people alive, giving them the best opportunity to fulfil their potential, um making moral values, in terms of what's right and wrong and being pressured in life to look after yourself, i.e. don't put myself under too much stress, is the importance of giving to other people and something which loosely influences me which isn't religious, well it is religious, but not religious in the common sense, it's more um, I'm a more philosophical person like, Buddhism influences me enormously, so doing things for other people without exaltation that you necessarily, you do it because you know it's the right thing to do. There's a value, that's a value driven behaviour. **(B4a)**

This value of altruism also brings conflict for some nurses. Examples were given from participants in both healthcare providers: the good nature of one manager being taken advantage of, to the detriment of his home life; and in the acute healthcare provider organisation, short staffing leading to distress when unable to provide the level of care that is perceived as a minimum standard.

Equality encompasses personal qualities such as fairness, and having the same rights, privileges or status. The nurses in Altun's study provide nursing care based on individuals' needs irrespective of personal characteristics. The following excerpt from one of the mental health team practitioners highlights this value of treating people equitably, and is based upon the values within Buddhism which he follows:

'Maybe it's fairness, with people who I have many reasons not to be fair towards. Objectivity is another value that influences my practice. I've had people who have really upset me and I'm sure there is times that I have really upset them but, It's been unintentional and I've apologised, that's quite unusual, but people, but even when people have been openly slating them, and been condescendingly quite derogatory about them, I will try and defend them. And I hear myself doing it and think, goodness me why are you even bothering? Well it's a value of fairness and being objective and I'm a manager for these people and if I don't defend them who will? They let themselves down enough already, so why should I try and get the boot in. There's no being angry with them, that's more about the Buddhist sort of stuff that I'm interested in. It's like being angry with them when they are angry with me, I should still show compassion and be caring and believe that they will come round to being good people, then they might not, but what is the point of responding? So my use of compassion, fairness, acceptance, something about accepting what I can, you know the old serenity prayer'. **(B4a)**

Freedom involves personal qualities such as self-direction, self-discipline, independence and the capacity to exercise choice. Those who hold this value honour individuals' right to refuse treatment and support the rights of other providers to suggest alternatives to the plan of care.

'I think it has changed really, I think it is more geared to what the patient's needs are really rather than the medical model of purely this is the medication and you must comply with medication. It is now looking at what the patient wants and looking, cos actually looking at what they want is totally different than what I think. I have to think, do they want treatment of the symptoms, you know, they want to look at the side effects, they want to knock it back, but to them the financial things, housing, relationships, developing new friends is probably more important to them. The medication is probably fifth or sixth on the list of things that they're worried about, you know and my philosophy now is really working with them at an early stage

and looking at what are your needs and what are your goals. Sort of holistic care but very specific to what they want, which some doctors and some consultants find difficult, cos it's all about getting them on medication, are they compliant? Unless they are taking medication they are not complying with the treatment.' **(B8a)**

Human dignity is the inherent worth of an individual (Altun, 2002), and relates to personal qualities such as kindness, respect, honesty, trust, promise keeping and empathy. Respect and empathy, along with patient-centred approaches were the values most frequently cited by participants:

'Personal values are about, yes those come in as well, about I believe that people should recognise their contributions and their strengths, I hate it, one of my biggest, biggest bugbears is when people take the credit for something you've done and you don't get acknowledged, I really, really hate that. I hate when people aren't open and honest with you, so I guess that also drives me, I am open and honest with patients, I don't tell them they're going to be fine and they're going to get better, I will be honest with them, straight with them you know, um and respect what they can do and try and build on their strengths and values and everything else into the plans that we can put together.' **(B1a)**

This honesty with clients was discussed by several participants within the EITs and was closely associated with being client centred, linked to the inherent philosophy of early intervention. Promoting dignity for the acute team was much more embedded in the provision of basic patient care, and centred on the challenges as well as the promotion. The following excerpt illustrates how one nurse actively promoted dignity through privacy in his practice area:

'I was a bit concerned about the curtains. This was just after I had started here and I was a bit concerned that people were just throwing the curtains back and just walking in and not saying anything. So I read around it about privacy and dignity and how you can stop people just opening the curtains. The best answer that I found was for protecting privacy and dignity was just

putting pegs on the curtains. A simple thing; so I went out to B &Q and I bought a big bag of plastic pegs, spoke to the staff about it, said look this is the problem yeh they all agreed. And I said to them that the only thing that I can think of is pegs and I told them what reading I had done, gave them all a peg and they started using them.' **(A5)**

Justice embodies personal qualities such as morality, courage, objectivity, and upholding morality. Nurses, who engage in this value act as healthcare advocates, allocate resources fairly and report incompetent, unethical, and illegal practices objectively and factually. The majority of the participants in the mental health team cited that they had consciously, over the course of their career developed a patient-centred approach to their care. The underpinning philosophy of early intervention as an effective means of treating clients with psychosis was seen as reinforcing the mental health teams' value of being client centred. Several of the mental health team discussed how their approach had developed from feeling dissatisfied with experiences of client care within other healthcare settings such as acute services. This and having effective role models had led them seek out alternative approaches to care. All of these approaches were based on being client centred and ultimately reflecting the early intervention philosophy. The majority of participants, to varying extents, had become advocates of the Recovery-Orientated Approach, which was reinforced by the healthcare provider organisation. This approach promotes the notion that people can become active, equal partners with professionals in their own recovery from mental illness. Solution-focused work with informal carers, professionals and clients, along with an understanding of what recovery means to the individual, can lead to successful management of mental illness. The following excerpt expresses one participant's views that reflect this value of justice:

'I think just promoting a positive view to recovery, yeh, on its own, promoting a positive outlook with a client and his family right from the first people we had. I am not sure if that's because it's who he is, or there's been a few people but, he seems to react a lot better to it, thinks well this isn't the end of it, this is the beginning of a big illness, it's just a few things I've got to work out over here you know and keep a check with those things.

> And him and his family both responded really well to that, um in fact sort of there has been times since when he has been seen by a consultant who may not share that view, you know and he has said to me afterwards, 'god you know I was told, there's a good chance of recovery, I understand what recovery means, and he just doesn't think that way does he?' But, it wasn't, that's different and I think that his positive views would be possibly different if he was, if he didn't have that kind of background you know, he probably wouldn't have been able to understand what was going on and his family wouldn't have been able to understand what was going on as much, and he would have a month or a little bit more, and possibly you know he would think, well this is it now, this is it for the rest of my life. That's probably that worked.' **(B8a)**

There are times when the nurses' values, and those of their colleagues or the organisation within which they work, conflict with each other which leads to an impact on their practice. The conflicts that participants experienced ranged along a continuum from severe to manageable. Conflicts causing distress, as illustrated by the excerpt below, were in the minority for participants:

> 'The time I worked at Ashworth as well with sex offenders as well, I found that quite difficult as well, especially if you've got children of your own. You are talking about non-judgemental and unconditional positive regard and all this Rogerian stuff. I found that quite difficult there as in some of the things they tell you, you know. There was lots of supervision there and it was needed. But I found out I was taking a lot, in those cases I was taking a lot of my values I think, and my beliefs. Now I can hold them back a bit more I think. Of course you get desensitised to it. Because you see it more often, it becomes more the norm, but I think again with the sex offenders, sort of thing, I think, I still find it difficult, I do work with them you know. It's still there, you think, you're giving me all these suggestions, why you do it? But at the end of the day the under 16's haven't given their consent really. I still find it difficult to understand why you do it sort of thing. I think it does impact on your engagement. I think you are probably less empathetic with

> that client group. I am anyway; I'll be honest when I have supervision. I will care coordinate, but I couldn't care coordinate twelve of those client groups. One or two, otherwise it would affect me and I think it would burn me out, and it would affect my relationship, working with them as well.' **(B3a)**

The literature suggests that when nurses encounter conflict between their values and those of the organisation, they experience a personal and professional struggle in relation to their needs and what is appropriate for the patient (Varcoe, et al., 2004). This conflict can have a severe impact on the individual, leading to moral distress. The concept of moral distress occurs when individuals are not able to undertake the right actions in their own eyes because of constraints within the organisation. The above example above falls into this category of moral distress.

At the other end of the continuum, a conflict within the values of participants is in the role of nursing care. Participants from both the nurse champions and the EIT valued hands on care, as opposed to the managerial aspects of their role. Most of the nurse champions went out of their way to make time to deliver patients' daily care. The mental health team's role, however, is predominantly working closely with clients as partners in resolving mental health and related social issues. This client centred approach is valued and conflict arises for them when tasks have to be performed that are perceived to be time consuming, not necessarily in the client's or nurses' interests, and taking them away from client care; one example being the use of computerised client records which create challenges and are time consuming for nurses who are not computer literate. The following excerpt is taken from one of the champions and reflects this conflict in nursing values:

> 'I do my best to; that can be quite difficult. One of the reasons I don't like nursing now because I worked in a nursing home for 10 years, so obviously it was hands on all of the time, I worked with healthcare assistants. And then when I was a student I worked with healthcare assistants and trained them as well. Once you actually get your qualification, you don't really have hands on. Weekends, I love working weekends because you do have more time for the patients.' **(A7)**

This valuing of the caring process is part of aesthetic nursing values. Fagermoen (1997) suggests that the meanings that nurses put into their nursing practice is reflected through their aesthetic knowing in nursing. The expression of their nursing practice is therefore a combination of their personal and professional values and meanings acted out in the workplace. Fagermoen (1997) goes further with this argument and suggests that these aesthetic nursing values are crucial in the development and sustainment of professional identify. This goes some way to explain the significance of hands on care to participants. This excerpt also reflects what is happening in the broader context of nursing nowadays: external influences have meant that there is a gap in the nursing profession between the patient/client centred care that most nurses value, and the organising aspects that go with promotion, prestige and a better salary (Gastmans, 1998). A hand on care, nowadays, is delegated to unqualified, healthcare assistants who have a lower status within most organisations.

Participants identified personal beliefs that impacted on their practice, one of which was religious beliefs. Several participants stated that their practice was underpinned by their religious beliefs, which in this case below caused some conflict:

> Um, own personal values, I think they can have a positive effect on your practice, but there are things that you have to keep very separate, really don't you? Like I'm a strict sort of Irish catholic and I'm working with you know Muslim males, but you have to keep your own sort of beliefs, keep it aside really don't you. I will, I'll get involved but I just don't like to sort, you have to be careful that you're not sort of forcing your sorts of opinions and thoughts onto people don't you?... I know they're my beliefs, they are my lifestyle. This is work, everyone is different and you just need to remember that don't you. Even my thoughts on different things, like I was saying before, you have to be careful. I am just really conscious that I'm not saying 'well I think you should do this'. I always try and make the patient identify what they want to do. Rather than push my own sort of opinions onto them and make them think that I think this is the right course.'

6.5 Summary

Analysis of the data has shown that experience is the foundation of nursing practice; it guides and develops nurses' skill and knowledge, and results in practice development and change. The literature on experience centres around experiential learning (Fowler, 2008; J. Moon, 2004) and the reflective process (G Rolfe, 2002; Taylor, 2003; Teekman, 2000). In both instances the nature of the experience is structured and controlled to promote learning, and in nursing, mostly applied to student nurse learning. There is very little available literature that identifies the nature of nursing experience that happens on a daily basis is out of participants' control and very often is unexpected.

Within this study a substantial number of participants identified positive experiences as being the stimulus for them to change their practice. This positive experience reinforced their own values and made them feel good about themselves. Other types of experience that impacted on practice included those that were negative, created by others in the workplace or the organisation, first hand and repeated. The participants identified that day-to-day experiences increased their knowledge, particularly experiential or practice knowledge. This was often at the expense of empirical knowledge or evidence based practice and the learning from programmes of study. This practice knowledge was valued above the other forms of knowledge.

Being experienced, as the majority of the participants were in this study, does not necessarily lead to improved performance. There were examples in the study of poor practice as well as effective practice. The literature suggests that experience can lead to more patient centred care and this was reflected strongly within the finding of this study. Likewise becoming experienced leads to improved confidence in day-to-day practice and participants valued sharing knowledge and skills with less experienced colleagues.

Across both healthcare provider organisations, the majority of participants were able to identify both specific nursing and personal values and how they impacted on their practice. The most frequently cited values that arose from the research

were being patient/client- centred, empathy, caring, respect and altruism. Conflict can be generated when participants' personal values conflict with those of the profession and the organisation within which they work, and examples were given of these. The literature on values centres on professional nursing values, and there is very little in the literature on how personal values impact on practice (Arbon, 2004). In this study participants' personal experiences were cited and included having episodes of depression, close relatives with mental health problems, and accessing the services as a client as opposed to a professional. Empathy was increased as a result of these situations and had a direct impact on patient/client care. Other personal values cited included following a religious framework such as Catholicism or Buddhism, which led to conflicts when dealing with patients or clients and having to adjust feelings and responses.

CHAPTER 7

MAKING SENSE OF PRACTICE

7.0 Introduction

The previous two chapters have explored how participants understand practice change and development within their role. This has included external and internal influences such as the evidence based practice agenda, and organisational quality assurance initiatives, for example audit and guidelines. Response to change both top down and self-imposed has been described, as well as the roles of experience and personal and professional values. This chapter will examine how participants make sense of their practice, turning to significant other professionals in the workplace, both on a one-to-one basis and as part of the supervisory process. Linked to clinical supervision is reflection, and how this influences practice change and development will be included. As with previous chapters a continuum will be identified which is part of the developing theory of practice change and development, and a collated version will conclude the chapter.

7.1 Support from significant professionals

Participants across both healthcare provider organisations recounted how colleagues and other professionals influenced their experiences and ultimately their nursing practice. These colleagues could be seen as a resource which increased the participants' knowledge base, filling in the gaps. They can also act as role models for the development of skills, can be inspirational and impact on participants' underlying philosophy of care. Other examples arose of colleagues' poor practice influencing participants' caring.

Increasing participants' knowledge and acting as a resource is one of the ways colleagues impact on participants' practice. This is highlighted in the following excerpt from a participant from the acute healthcare provider organisation:

> 'Yes it was roughly about 10 years ago and it again was a very difficult pressure sore, if I remember rightly and we had had to ask for his help as the products or whatever we were doing, and the sore was quite severe, it

wasn't improving. He came along and quite efficiently and quickly once we had referred and again he could sort of identify and explain what was going on with the wound and suggest a product that would help us to start coping with this. I felt that it did work. You know that's what struck me was that there was far more to it, not just for what you actually see, but what you actually have to think about. Yes and again reiterated I suppose the physiology of what had happened to the deep underlying problem that the patient had. You know the stages that a pressure sore went through. I mean we learn all of that through nurse training, and if you are fortunate enough through your training to see a severe pressure sore, that's all very well but again if you do, you may only be dealing with qualified staff who aren't quite sure on how to deal with it. So effectively I felt that the likes of the specialist nurse was more effective to the point without us having to be wandering in a quandary.' **(A1)**

This excerpt highlights an example of seeking experiential knowledge from colleagues. Experiential knowledge has been discussed in the literature for many years. This type of knowledge is gained through everyday practice, and is based upon what works, what doesn't work and as a result of intuition (Easterbrooks, et al., 2005). Such knowledge is synonymous with Rogers (C. R. Rogers, 1983a) description of experiential learning, and with Polanyi's (1958) concept of 'personal knowledge'. The majority of participants within this study highly valued the knowledge gained from experience and referred more frequently to this than any other source, including formal knowledge such as that learnt from educational programmes and evidence based practice.

In this study nurses from the acute healthcare provider organisation turned to a range of professionals including peers and managers, but less so to other professionals. The Early Intervention Team had access to group meetings to provide this support and gain access to resources and knowledge. These were both formal, set up by the managers, or informal, at the end of the day when all of the team were likely to be together. Both were seen as an opportunity to discuss and get advice on general or client issues. The majority of participants alluded to these

groups as having positive and supportive functions.

The following excerpt is taken from one transcript where the participant's underlying philosophy of care has changed due to the influence of a colleague. This use of colleagues to influence philosophy and values within professional practice was commented upon by several participants within the mental health provider organisation. The colleagues referred to were either another nurse or an alternative professional such as a medical consultant. The converse was also referred to in instances where participants worked with managers who they felt were not good role models; they would not like to be associated with the practices that they saw. In this instance the colleague acted as a motivating force, enabling the participant to see the positive, negative, and alternative ways of working and providing support and supervision.

> 'Golly, yes I guess round about the same time, because I went through a period, I worked on this inpatient ward for about eight years, you come to the conclusion that there must be something more to it than this, you can't just give people medication and lock them up, there's got to be something more and around that time I started to become aware of the Psycho Social Intervention Movement and wanted to do that and as I started training we had a team manager start, a community team manager, in post who gone through the Thorne training previously and she acted as supervisor for me during the course but even as a managerial position she'd got a real drive and passion about patients, about the PSI model and wanted to do more, medication was just one little aspect of it. There was far more to treating people with psychosis than drugs. And she made a huge impact in terms of encouraging me and likewise with those people who have that very custodial, non-risk taking medication and biological sort framework and they've also inspired me in a way not to stay in that box, you know there's got to be more than this. Seeing the positive and being taken down that road and also seeing the negative and not wanting to be like that. It's knowing that there is more to mental healthcare than that. It can happen to anyone, I mean if you were ill you would hate to be treated in that manner

so that's also been, I don't think inspirational is the right word but it's a motivating factor anyway.' **(B6a)**

In this instance the community manager was acting as a role model. A role model is someone who sets a positive example (G. Holton, 2004), and acts as a 'catalyst to transform as they instruct, counsel, guide and facilitate the development of others' (Bartz, 2007, p. 7). Kramer (1974) suggested that effective role models are those that take risks, use their experiences to relate to patients, are perceived as standing up to management, take responsibility, and are self-critical and creative. Social Learning Theory focuses on how people learn within a social context and from significant individuals within that context (Ormond, 1999). Bandura's Classic Social Learning Theory proposes that most human behaviour is learnt through observation and modelling (Atkinson & Hilgard, 2003). An individual's values can also be influenced through role modelling. Bandura suggested that 'individuals are more likely to adopt a modelled behaviour if it results in outcomes they value' (Bandura, 1977, p. 29), and they are more likely to adopt this behaviour if the role model is admired and perceived as similar to themselves, which can be seen in the example above. This was apparent in this study where role models that influenced participants' philosophy were perceived as being competent and knowledgeable and showing attributes that were admired.

The following excerpt is an example of one participant who imitated the practice of a peer knowing that this was an example of inappropriate practice. This is also an example of the Social Learning Theory but in this case it is learning vicariously. Vicarious learning is learning through the experience of another. Learning in this manner usually refers to a situation between peers, who share a similar status to each other, and are generally not there as teacher or expert practitioner (Boud, Cohen, & Sampson, 2001). Vicarious learning, as can be seen from this example, can result in inappropriate practice knowledge:

'I've only ever seen one community nurse wear gloves and she wore one glove, and that was to give an injection and she just worked on the one that touched the patient to give the injection. And that was only because she'd

had needle stick injury. Because she wasn't wearing a glove, the healthcare provider organisation wouldn't support her. So I do that. On that hand that might get pricked I tend to do that, particularly now there's the really thin blue glove. Because before they were like, you couldn't feel anything or do anything, particularly giving an injection in somebody's house. I think so, yes it was a direct result of her relating that experience that she'd had a needle stick injury, she'd had the HIV course of medication, um and the healthcare provider organisation wouldn't support her.' **(B3a)**

For both teams, their manager was significant in supporting practice change and development. The manager was seen the leader of imposed practice change as well as the link to other sections within the organisation. Their role included a range of functions from offering clinical and managerial supervision, ensuring equity of resources across the team, as well as leading imposed practice change and development. The managers weren't necessarily seen as the expert in practice, but all carried a case load and valued the patient/client contact. The following example highlights the perceived need for equity of access:

'I find that for me personally a great instigator for change is the actual manager. In the sense if they support me in my ideas or contribute, I find that a great help, or even put me forward for further training. I like that push from them and to further develop. This has been a problem in past years because of staffing levels. It wasn't always the thing to be allowed time off the ward to attend you know, research, whatever. It is pulling through far stronger now than it ever did before. Even though it was tried, it was the whole aim over the years. I think it is only the past couple of years I feel that they are making sure that we are allowed this time away from the ward to help with our updating and development.' **(A1)**

7.2 Teamwork

Being part of an effective team was highlighted by most participants as having a major impact on their nursing practice and development:

'You would hope that that change would then stay as it is. It would be an absolute priority, it should be anyway, but I am only using it as an example, but again for me it the amalgamation of getting staff to work as a team or that might just be me personally. I think that in the ideal world you're hoping for a happy team, a team that can fulfil and express their own ideas and we can all kind of grow together. With extra staff it's not just having extra staff, it's having regular staff, in place that whole twenty four hours, seven days a week kind of scenario, extra staff isn't the gateway there we're looking for, it is constancy, and what I feel the change is that the constancy we have is compromised all the time. Change becomes slower, or it will have little sort of runs when it is good and then things decline again. It needs to be kicked into progress again; depending on what levels of staff you are dealing with, regular staff, pressures that way.' **(A1)**

7.3 Clinical supervision

The majority of the mental health team referred to the benefits of having supervision as part of their working practices. Only one participant from the acute healthcare provider organisation received any sort of supervision, and this was from a manager and was highly regarded. Supervision is an integral part of mental health practice and is supported by the statutory regulatory body (NMC, 2006). Bernard and Goodyear (2004, p. 8) defined clinical supervision as 'an intervention provided by a more senior member of a profession to a more junior member or members of that same profession'.

The benefits that participants recounted as a result of supervision included an opportunity to reflect on care that they provide for individual clients, checking that the care being provided is right and changing or amending it if appropriate, filling in gaps in information such as availability of services, and setting goals for professional development. All impacted positively on participants' nursing care. Good supervision was highly valued by all the mental health team, although it was acknowledged that this was not necessarily the case for all supervisory experiences.

The following excerpt was highlighted by one of the mental health team as an example of how one supervision session impacted positively on his practice:

> 'My past team leader he sort of suggested other forms of medication, you know and I had this patient basically suffering a lot of phobias you know and he wouldn't leave the house. He was very anxious; he also had a lot of acne as well. So he was seeing the GP cos of his acne and antibiotics, but turned out it was more of a side effect of medication he was on. It was a side effect and I had never known it. But he was aware of that, so his experience of past medication and treatment, he could tell me, passed that onto the doctor, changed the medication, acne was reduced, and patient could go out. You know something as simple as that, suddenly made this patient who was socially phobic, you know, wasn't engaging at all, in three months was then leaving the house, you know.' **(B10a)**

Other benefits of supervision identified by participants included personal support and development of their self-awareness. The following excerpt highlights how a manager saw the personal benefits of supervision:

> 'When I reflect back on a supervision sessions sometimes I go in feeling really busy and often I come out thinking, this is much more manageable because you're allowed, being allowed to take everything out of your brain, throw it onto the table and put it back in an organised way. And that just settles you down, you know.' **(B4a)**

Development of participants' practice by target setting and follow up was highlighted as one of the benefits of supervision. The following example is from one participant who on qualifying was supervised by her manager in order to increase her confidence and skill development:

> It, they were really, really small goals initially, just like you know to do with medication, cos I had never done it, making sure I knew all the side effects of the anti-psychotics, general doses and antidepressants. Common

medications that we were using on PICU at the time, care planning, never wrote a care plan until the day that I started.' **(B6a)**

This relationship successfully continued for several years, despite the fact that they are no longer working in the same area. The balance has changed, however; the process now is more one of joint supervision with both parties benefiting. This was a common theme with supervision starting for one reason and continuing longer term with added benefits.

Literature reviews have identified that there are a number of differing models and there is no actual evidence that clinical supervision impacts positively on practice and nursing care, but has benefit as a support process as a means of stress reduction (Brunero & Stein-Parbury, 2008; Buus & Gonge, 2009). Participants of this study, however, perceive that their clinical supervision has a positive impact on practice change and development and is also supportive to them as professionals.

Three types of supervision were identified by participants. These included management, clinical and informal supervision undertaken as a group, both formally and informally. Clinical supervision was identified by participants as being client based, providing an opportunity to reflect on care given, and very often the participant chose the supervisor themselves. Generally participants had some choice of supervisor for clinical supervision and this was based upon past experience with the person, either within the workplace or as an assessor following an educational programme, and involved some degree of being comfortable with that person. The organisation also offered clinical supervision and this was multidisciplinary and not mandatory. Participants recounted that clinical supervision impacted on their practice and could provide examples of when practice changed as a result of this supervision. The following excerpt reflects this process:

'Used to have supervision, initially it was weekly and then after that it was like fortnightly or monthly. She used to review through your caseload and I saw her as – I didn't see her for management supervision, it was just clinical supervision. Looking at what I was doing with my clients, whether I needed

to be seeing them as often as I was, and then because she had been in the services for a lot longer shed say 'have you tried this or what about that?' That's something you just pick up as you've [been] in the services for such a long time you just know what is out there for people.' **(B2a)**

Management supervision was seen by participants as a much more formal, mandatory process, carried out by a manager and involved reviewing their performance and setting targets for development if appropriate. The following excerpt highlights how one participant viewed the difference between management and clinical supervision:

'Management supervision – it tended to be, it was quite, much, much more formal and sort of targeting areas for improvement and setting sort of objectives and you know it was quite structured my management supervision was, whereas the other supervision, I found that more supportive and that was more just talking. That was the difference for me I think. 'Cause that was someone I chose and valued and felt really supported by her.' **(B6a)**

Management supervision was seen as both supportive and at times unhelpful. There were also challenges when the supervisor was also the person's manager as to what the supervisee feels comfortable to divulge:

'We have a service manager who manages four of me, five of me and I pretty much do ninety nine point nine per cent of the job. But they get paid as a service manager to manage my service. But they're involved in lots of other things out there, meetings, deaths, complaints. Meetings, meetings, meetings about new change and so meeting me is, so on the one hand I want to portray (during supervision) that things are going well, cos they are, but that's fine. I get questions like 'How can I help

you? What's going on for you at the moment?' Or maybe I need to take more responsibility and utilise that more. You know but it's, there's so many other things that come up like, OK how are we going to spend the half million pounds? And I have to, I've got a plan here, I've written it all out, here you go, there's how I see it over the three year plan. Recruitment, meeting targets for caseloads, um dealing with staff who are under performing. Um where are we going to move to when we have five more people starting in two months' time? When do I get that piece of the answer, I don't get chance to think about me? That's the honest truth and that's not being a martyr, it's just that's what I do a lot, don't get a chance to think about my own needs.' **(B4a)**

Although participants referred to both types of supervision, the process seemed to be interchangeable according to the supervisor and their preferences. In several instances both clinical and management supervision were identified as exploring client care.

Participants recounted how important informal group supervision was in terms of developing their practice. This is known as 'pit head time' which is an analogy to working at the coal face (Driscoll, 2004), and the following excerpt highlights this:

'But as a team what we also do because you've seen the office with the circular desk, so everyone is around it and we talk and we have like the old fashioned sort of pit head time, like the canteen culture really where quite often issues will be discussed or problems will be brought to the table. Or else if other people pick up something's not right they'll challenge you at the table and sort of say what an earth are you doing by doing this or have you not tried doing something else.' **(B2a)**

This formalised 'pit head time' was peculiar to the mental health team, although in the acute healthcare provider organisation, support in this way took place in the

canteen, over coffee and lunch where challenges and issues were discussed.

There is confusion within the literature regarding definitions and approaches to clinical supervision (Buus & Gonge, 2009). The most popular and most widely used is the Supportive Model (Butterworth & Faugier, 1992). None of the participants was able to identify a recognised framework that they used either as a supervisor themselves or as a supervisee. The excerpt below is taken from one participant who was an experienced supervisor and valued being supervised:

> 'I wouldn't be able to, I guess I couldn't cite exact models, I mean I could tell you I've been on supervision courses and um I've had lots of different structured processes for the interview, different subjects, clinical, reflective, managerial whatever it is. No particular model I can think of.' **(B2a)**

Multi-professional supervision is available also to the mental healthcare provider organisation. This was seen as management supervision. These sessions were valued, but seen as one off, drop-in scenarios, not the longer term development relationship. The following excerpt highlights this type of supervision:

> It's mainly management supervision to be fair, supervision I get with the psychologist. For clinical stuff, while it's more psychologically based stuff, you know. She has a regular spot where you can access where you can access her time you know. And that's if you've got a patient that you're not sure how to deal with, or you want to know how to deal with them but you're just, you want that constant checking, you know to make sure you're going down the right, cos it's tricky sometimes, you could be doing completely the wrong thing.' **(B8a)**

7.4 Reflecting on practice

The process of reflection was identified as a key part of supervision. This section of the chapter explores how participants make sense of experiences that they have during their everyday working life through reflection, which may lead to development or change of practice. Part of this sense making involves using the reflective process and engaging in reflective thinking. All of the mental health team

recognised that they routinely reflected on their practice and saw it as an integral part of developing their practice. The majority of them linked this reflection to the supervision that they received. This was less so with the nurse champions, only two of whom were aware of using the reflective process. Teekman (2000), following research into nurses' reflective thinking, suggests that reflection is a response to a gap producing situation and involves a range of cognitive activities such as self-discourse to make sense of a situation or phenomenon in order to act. This process contributes to better understanding of what is happening within the context and influences future behaviour (Teekman, 2000, p. 1133). This section will discuss the types of reflection that participants undertook, what they gained from the process, and how this links to practice change and development.

The majority of the seminal literature on reflection alludes to Schon's typology of reflection, which includes reflecting in and on action (Schon, 1987). Reflection on action is the 'reflection on a situation or experience after the event with the intentions of gaining insights that may inform future practice in positive ways' (Johns, 2009, p. 10). This reflection on action was the most reported form of reflection within the study, although none of the participants gave their process this name. Reflection in action will be defined and discussed later in this chapter.

This reflection on practice was often carried out after the event when there was time at the end of the day, such as in the example below, where the participant reflects in the car on the way home. In this instance the reflection helps in putting events of the working day into perspective, and allowing the participant to make sense of what happened and putting it on one side before starting the evening.

> 'I tend to do it on the way home or I mean I live a way a way in the country so it's a nice drive home so that's my time and I do try and do try and do a bit of a wind down and try and put things in perspective really. Otherwise you just go away and go crazy yourself, wouldn't you? It's a period of reflection and I guess I also do it through supervision as well.' **(B1a)**

Reflection on practice was also quoted as taking place successfully when carried out in a group and this approach was highlighted particularly by the mental health

team. The following excerpt on reflection is by two nurses who had given a teaching session on psychosis, in a refuge for homeless young people. The session had not gone well and the group were discussing what happened, the difficulties of planning in advance, and how the session could be improved in the future:

> 'It's not formalised, it's just sort of talk amongst yourself and sort of you decide between yourselves, we're not going to go down that route again, we're not going to do it that way again. It worked better if it's done this way. The hardest thing is trying to fit it into your working day anyway, trying to come up with your plan, what you're going to do, and get together with the person you're supposed to be doing it with.' **(B2a)**

Participants reflected on other professionals' actions and compared them to their own in order to develop new skills. This was common, particularly amongst the mental health team. The following excerpt highlights how the participant intuitively reflects on other practitioners' actions in order to improve her own:

> 'I mean I do reflect, but we don't sit down and write it down, but I think I take away a lot from the other practitioners in the team, I'm the youngest as well and I do try to listen to how they conduct their sessions, and try and take it away and think you know maybe I should try that or, if I go out on a session myself, sometimes the sessions are really successful visits and sometimes they aren't. And then I go back and you know, maybe you will reflect, but it's more sort of, I don't sit down, I just do it.' **(B6a)**

None of the participants discussed reflecting into empirics that underpinned their practice. Only one participant kept a practice portfolio, although several suggested that they should, as part of their professional practice. This participant, from the acute healthcare provider organisation, had been reflecting on critical incidents for most of his nursing career, and as the excerpt below highlights, tends to turn to other colleagues rather than the underpinning evidence:

> 'I mean if I am finding it difficult enough to look at a situation and look at both aspects, then I will look, I would go and look to see if this is the right

methodology. But I don't really usually do that. I think you could also call it clinical supervision as well. You know I do speak to other ward managers about situations, and vice versa, they do as well. They say well you could have done it this way, or you shouldn't have done that. Yeh but you did the right thing.' **(A5)**

Reflection in action has been defined as 'pausing within a particular situation or experience in order to make sense of and reframe the situation in order to proceed to a desired outcome' (Johns, 2009, p. 10). The following excerpt highlights how the participant discusses with herself how she can manage this situation and safely remove herself from a situation where the patient is becoming aggressive:

'I wouldn't think of a routine set, in your head, you just go into it. You'd just be thinking how am I going to either calm the situation down, how am I going to get out of it? What is the, maybe not listening what they are saying to you properly at that time because you are thinking what I am going to do? I'm trying to think what, I am going back to Community Mental Health Team when I was in a situation when I felt quite threatened by this girl and I was on my own in her house, she was standing over me shouting and I'm thinking what am I going to do here? I think I just kept it calm and just sort of said you know I will discuss it with whoever it is if that is OK with you, and I'll make another appointment with you now as well. That was the end of it really.' **(B6a)**

Teekman (2000) identified three different foci of reflective thinking: thinking for action, which equates with Johns' reflection on and in action; reflective thinking for evaluation; and thinking for critical enquiry. Reflective thinking for evaluation focuses on analysing and clarifying individual experiences, and could be identified as ongoing development of self-awareness (G. Rolfe & Gardner, 2006; Teekman, 2000). The mental health team value the development of their self-awareness and see it as contributing to the positive development of their practice. The following example highlights how self-awareness developed through reflection, as one of the team developed the new service:

'Um I suppose I already had a lot of the skills, I was already a team manager when I came up here so I'd already been, it just became a lot more intense, not knowing people and not being known made it more difficult for me being in this area cos I was just some guy from Liverpool who'd come from London, so I didn't know anybody. So it's quite an isolating job when you don't know anybody and you're one person representing a new service. Um so I suppose I did a lot of it independently, I was quite isolated at times, quite unhappy in all honesty when I started. Um obviously it's a lot of reflective, sort of reflection in my own time, weekends, sleeping became a bit bothered. That sort of preoccupation, but that's my own style is that. I kind of criticise myself and eventually find out, no I didn't really do anything wrong there, that was part of the process of engaging other people and getting other people to trust me, and um getting other people to realise I can actually do this job and I know what I am talking about.' **(B4a)**

Despite the fact that the majority of the mental health team acknowledged that reflection was an integral part of their practice, none of the participants could identify a recognised model or framework that they used to undertake the process. A common process for reflection after the event was identified by several participants, and none of the participants reflected into the underpinning evidence behind their practice. The following excerpt illustrates the general process that was highlighted by participants:

'Is there a process I go through? Um, I tend to think about what's happened, how it happened, what was said, what the outcome was and maybe think about what would be a better way of doing it. Just go through the motions of: what did happen, what could have happened and how maybe I'll try and take it forward and next times do it differently. Yeh, yeh I suppose so sometimes, but again that, yeh it's like, I don't know, sometimes you go on gut reactions and sometimes you go on sort of the knowledge or experience or history or evidence.' **(B10a)**

Several of the participants related that the reflective process was a part of who

they are; it was intuitive and the process could not be vocalised:

> 'I don't think so; there is not a formulaic process. I think it um, its tend to be intuitive and I mean reflection is for me, because I'm always a bit of a people pleaser, I want to accommodate, I think it's about appearing good as well, and appearing to be the best. So that's what drives you, what drives me, in my case. You know I want to do the best; I want to do the best by the patient. But also ultimately it's about me feeling good or other people feeling good about me.' **(B4a)**

Participants identified clear outcomes that resulted from the reflective process that they undertook. Improving their nursing practice and patient/client outcomes was one key reason stated as the benefit and the reason for reflection. Making sense of situations, particularly if they had been difficult during the day, and getting things into perspective reduces stress and enables participants to cope with subsequent similar situations as they arise. Increasing self-awareness, which could in turn impact either positively or negatively on both of the above outcomes, was a further benefit to reflection. The following example highlights how the participant values reflection and the impact it has on practice, is self-critical, but also tries to get the situation into perspective:

> 'So sometimes I will go out on a visit and think that's really good, we went in, we identified the problem or you know the visit had a really nice sort of flow to it, the conversation was real, and sometimes I'll come out and think that was so disjointed, which is not always my fault. It might be the client's fault. But sometimes it might be and I will think maybe I should have held back asking that then or, you know, so yeh I definitely do that, which is probably a good trait to have.' **(B6a)**

There are also times when the organisation, particularly in mental health, requires the nurse, as part of the team, to produce reflective summaries following incidents such as suicide, in order to learn from what happened and be able to produce evidence for any subsequent formal reviews. The incident below is one example that was cited in the study:

'No it's probably done more as a team, group level really, probably with the consultant as well because he's very much part of the team. I'm just thinking of one incident. It was done more as a team type thing, saying was there anything more we could have done in this situation and there wasn't. It was very much down to the client, rather than down to our working practices. Because they've got that impulsiveness about them and I don't think you could ever with some clients ever stop that happening, but it's putting into place, what you can put into place to try and stop it happening. Like not giving them a month's supply of medication, just giving a week at a time.' **(B1a)**

As in previous chapters the continuum of practice change and development continues to develop and this section highlights how participants use professional colleagues to help them make sense of their practice; see figure 8 for a representation of this continuum. Findings from this chapter will be incorporated into the developing theory of practice change and development in Chapter 7.

As previously the continuum included a series of approaches. The first approach on the continuum is that participants' turn to colleagues for filling in gaps in knowledge, acting as inspirational people or role models. Some of the participants never move beyond this stage and amend their nursing practice based on these conditions. As the continuum develops, participants rely less on their local colleagues and access a wider range of resources, such as conference presentations and networks. They also themselves become a resource for others.

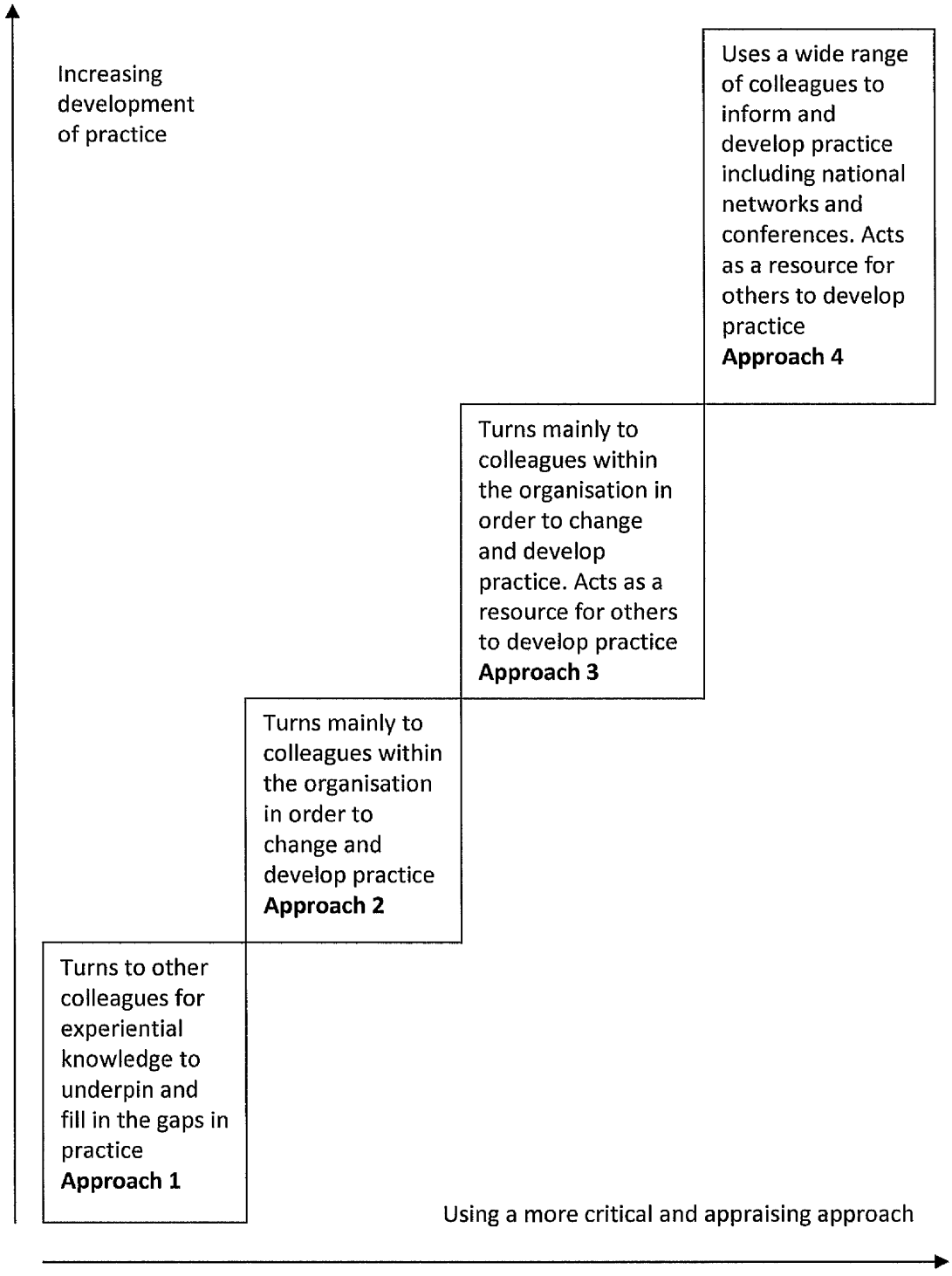

Figure 10: Continuum of practice change and development: Influence of other colleagues

7.5 Routines and rituals

On commencing this study one of the areas of interest was the role of nursing rituals in the promotion of or resistance to change in nursing practice. For this reason nursing rituals were included in the literature review and the subject was included in the initial interviews. The champion's knowledge of these rituals was explored during initial interviews and examples sought from their own practice with a view to ascertaining the role of rituals in practice change and development. All acknowledged that traditional nursing rituals or ritualistic practices were undesirable and commented on the efforts made by the profession to extinguish these practices. Examples that they gave were the bath and bowel books in which times that inpatients had a bath or their bowels had opened was recorded, patient observations and excessive fasting before taking a patient to the operating theatre. The literature review identified that there is a significant difference between rituals and ritualistic practice, the latter being examples of poor practice (S. M. Philpin, 2002; F. Strange, 2001a, p. 23; Walsh & Ford, 1989). The following is a definition that one participant provided of ritualistic nursing as being detrimental to patient care:

> 'Like we used to do years ago, that we did automatically without thinking about the patient?' **(A5)**

Participants, despite denying that they were involved in these rituals, unknowingly gave examples of nursing rituals current in their practice. In the following incident the participant identified how routine observations are carried out even when the patient is going home in the near very future. When asked to explore the rationale behind the practice, the participant devolved responsibility for decision making to the medical consultant:

> 'No I've just gone round and done some observations round the back and a lot of the patients are only on twice weekly observations. And I queried it, why are you doing this as the patient is supposed to be going home tomorrow. You can turn round and say that it is and the consultants will also guide if they want the observation continued on patients. Legally it is

actually a medical decision to turn round and say no we don't want the observations. There have been incidents where they haven't been done for a long time and the patient has all of a sudden deteriorated, and it hasn't been picked up on.' **(A6)**

The above is characteristic of ritualistic practice in that there is no rationale behind the actions, other than it has always been done that way (Hatton-Smith, 1994; Tonuma & Winbolt, 2000). This example also reflects Ford and Walsh's (1994) view on the 'ritualistic straitjacket' (P. Ford & Walsh, 1994, p. 23) which is 'the blind obedience to physicians and nursing practice that lacks the foundation of scientific research'. This participant was a manager who denied that any rituals were performed on her ward and had no insight into the example that had been provided.

Several participants gave examples of nursing rituals that had consciously been eliminated. The following participant had turned the sheet on the bed from top to tail when making the bed, as was common practice when she was taught by nurses in her initial pre-registration programme. The practice was accepted without question until one day she intuitively thought about the implications:

'Even silly things like making the bed. We got told that you swop it over. If anyone put my feet end up by my head the following day I would go mad. So I just turn it that way. And everyone does it that way now. I've got on my little high horse about it that often about it. I am still changing it round. I just think that's disgusting. Me I just would not like having my feet the night before close to my head. We talk about infection control and all things like that. Because I got taught the same way we all got taught, wrap it round and then I was on the ward one day and I thought, god how horrible. No to be fair to the other side, I know how my feet can smell as well. I know other patients must feel the same. But I know that I have passed it onto other like nurses and HCAs (healthcare assistants) and they go right I wouldn't like that either. Then they have gone and told other people as well.' **(A7)**

Apart from the ritualistic practice identified above, nursing rituals serve several functions. These were explored in the literature review and include reducing anxiety and distress, response to death and dying, and promoting values within the society of nursing.

The literature also identifies rituals as richly symbolic patterns of behaviour that define and strengthen the culture and profession of nursing (C. K. Holland, 1993; S Philpin, 2006; S. Philpin, 2007; Walter, 2003). Only one participant commented on the lack of underpinning knowledge to ritualistic practice, and how true nursing rituals are still prevalent in nursing and are essential:

> 'Probably to some extent because I think nurses need some rituals. A little bit of myth and ritual. Like you know putting a poultice on, a leaf picked at the full moon by a virgin with cross eyes. It actually does the trick but because you don't know which bit works, you just do the whole thing. I suppose we don't do it as much as we used to. But there is always that element there because you have to do things. I think we have eliminated an awful lot of rituals. People have an expectation of you.' **(A4)**

However what was apparent from analysis of the data from the champions was the overlap between ritualistic practice and nursing routines. Task allocation as a means of managing patient care was very prevalent in nursing up until the advent of evidence based practice, when it fell out of favour (Rytterstrom, Unosson, & Arman, 2010). Task allocation is the performing of one task for all patients that need that care and then moving onto another task. Examples of task allocation that are still undertaken are routine observations of temperature, pulse and blood pressure, and blanket baths. There is overlap between nursing routines and task allocation as some routines can be identified as task allocation and some stand on their own as routines. For this reason nursing routines and their role in practice change were explored in the interviews with the Early Intervention Team.

The following excerpt is an example of ritualistic practice which is also a routine and task allocation:

'When I first started on dermatology we had this practice where everybody with leg ulcers was in bed. You would go round with this one trolley, take it from the trolley, do a wrapping, and move onto the next patient. So I am pleased that we have got away from that. We clean down between patients and move on, do all of the leg ulcers. Lots of things, we have moved out of the nineteenth century.' **(A4)**

The nurse describing this practice was unaware that the ritual was still being implemented and thought that it had been extinguished.

Routines were seen to be a way of organising nursing care and all of the champions identified that routines were the backbone of nursing. In the example below the nurse depersonalises the patients through the routine:

Um, the whole shift tends to be a routine, you will have a routine from when you start your shift to the end of your shift and you just have to deal with everything that comes along during that shift like. Any unexpected poorlies, relatives and everything, you just fit in. You go in on an early shift and your routine is you do your CDs [controlled drugs], check your CDs, then do your beds, then make sure the bloods are all in and do your breakfasts, then your drug round. Then the patients are sorted. There are dinners, then obs [observations]. I think every shift has a routine; you just deal with everything that comes.' **(A7)**

Some routines are detrimental to patient care. The following excerpt is an example of where a patient routine, visiting time, was changed for the benefit of the nurses:

I mean at the moment visiting time used to be three to eight every single day. That was a nightmare, our visiting time. You wouldn't just have all of the patients to contend with, you'd have to work around relatives. Speak to relatives, do your obs round them. It was a nightmare. They've been changed now to between three and four and seven to eight. The difference is amazing. You do have more time for the patient. Don't get me wrong, the relatives are just as important but you would have more time for the

patient. They feel they get more attention and more, I can't say more care because the care has always been there and the care comes with the attention. The job is a lot easier.' **(A7)**

The literature suggests that routines can also be beneficial, both to the patient, nurse and organisation (Rytterstrom, et al., 2010; A. Smith & Stewart, 2011; Zisberg, Young, Schepp, & Zysberg, 2007). Many of the frameworks that are used in nursing practice require a routine for completion, such as mental health assessments and risk assessment tools in acute care. These serve to standardise and maintain consistency across nursing practice and can be a way of the organisation resisting change in its employees (Becker & Zirpoli, 2008).

7.6 Summary

Participants consulted a range of professionals to make sense of the experiences that they were having, including their peers, managers and other professionals. These findings concur with the research undertaken by Easterbrooks, et al. (2005), who found that nurses highly valued clinical experience as a source of practice knowledge and relied on colleagues for this resource. The two main types of interaction that facilitated this process were social interactions and experiential knowledge. Informal social interactions occur when the nurse perceives there is a problem and needs assistance to resolve it. This study found that participants turn to nursing colleagues more often than other colleagues because of the unique support that they get from this group. This includes both the practice knowledge and the affirmation and support that validate their feelings and actions. Again, this reflects the research undertaken by Easterbrooks et al. (2005).

The majority of the available literature on role modelling and nursing relates to mentorship and student nurses (Dameron, 2009; Donaldson & Carter, 2005; Price & Price, 2009), and nurses as role models for patients in the promotion of a healthy lifestyle (Denehy, 2008; Rush, Kee, & Rice, 2005). There is very little literature on the impact of role models in everyday practice for experienced nurses. This study found that nurses turned to role models for their development of skills, influencing their philosophy of practice and guiding their practice.

Supportive processes for promoting change in practice that were identified in this study were clinical supervision and reflection. All of the mental health team described supervision as contributing to them changing their practice, and reflection was seen to be an integral part of this process. The majority of supervisors came from their local workplace and all were valued.

Prevalent ritualistic practice was described by several participants, despite being identified as detrimental to effective patient care. Nursing routines were seen as the backbone of nursing care on a day-to-day basis and could still be linked to ritualistic practice.

The aim of this study is to research nurses' understanding of practice change and development, and how this is affected by their attitudes to change and other influencing factors. The theory of practice change is being developed from findings in chapters four, five and six. Figure 9 is a compilation of the findings from these chapters, expressed as a continuum. The diagram provides a profile of nurses in relation to their approach to both self and externally imposed change in practice, sources of knowledge that underpin practice, and the extent to which experience guides and influences the process of practice change and development.

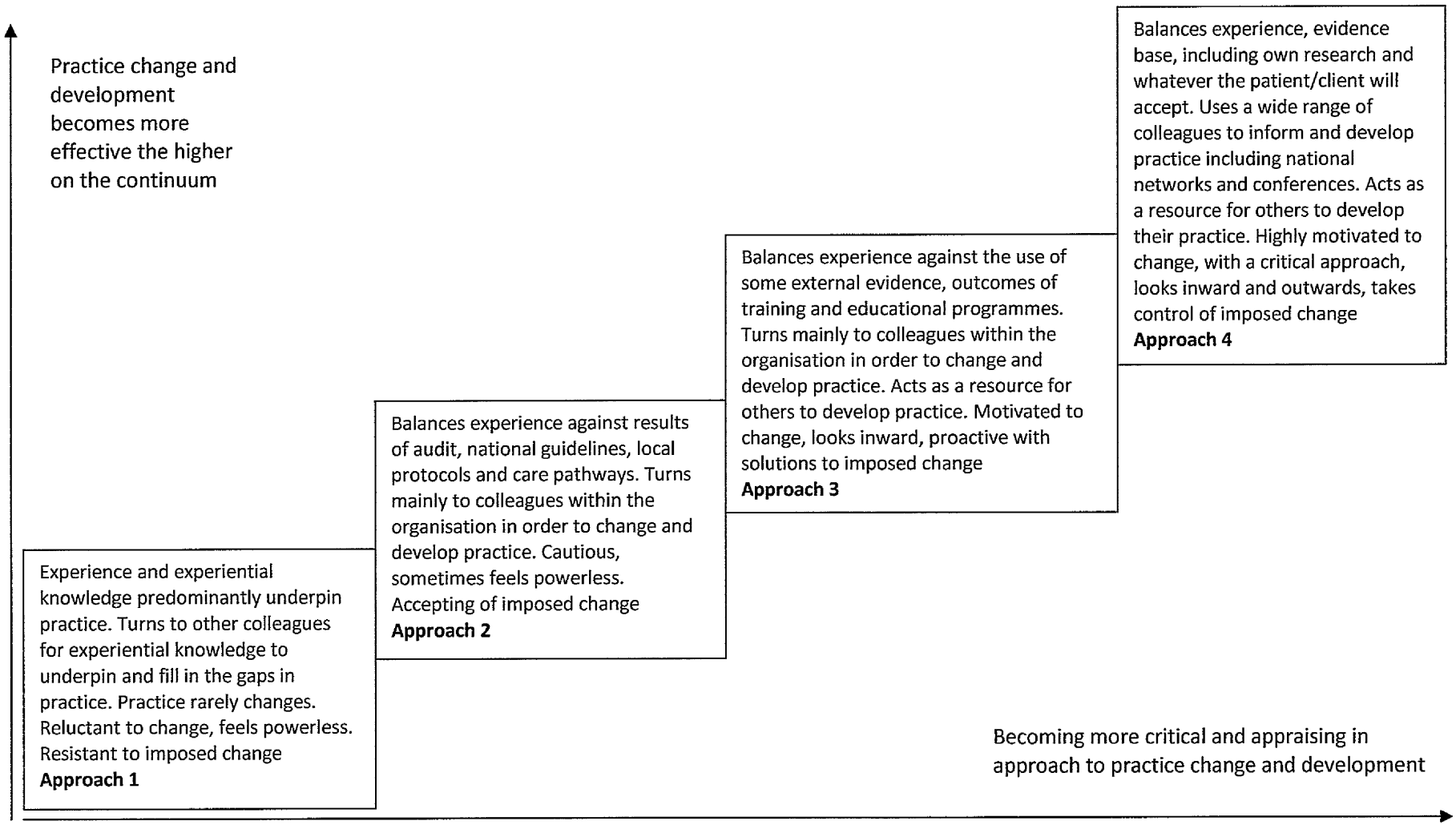

Figure 11: Practice, change and development continuum

CHAPTER 8

DISCUSSION: THE THEORY OF PRACTICE CHANGE AND DEVELOPMENT

8.0 Introduction to the chapter

This chapter will bring together all of the findings from the previous chapters and present an overall grounded theory of practice change and development. This theory will be substantive as opposed to formal. Where appropriate, reference will be made to the literature review in chapter two, and this chapter will also address the issues related to the research questions:

- How do nurses understand practice change and development, and how can it be described?
- What is the process that the nurse undergoes as their practice changes and develops over time?
- What is the relationship, if any, between practice change, resistance to change, and nursing rituals?
- What recommendations could be made to facilitate effective practice change?

8.1 The nature of change and nursing practice

The study found that nurses understood the process of practice change as a hierarchy with the most significant aspects of nursing change at the bottom. This hierarchy was introduced in the findings described in chapter four and summarised in figure 2, which is repeated below for convenience.

This description of the change process supports the theory of change identified in the literature review as defining nursing: promoting an ongoing process of change for the patient and their relatives (Hussey, 2002). This must also mean that change is inherent in nursing and happens continually. This notion of change is reflected in the classic definition of the unique function of the nurse (Henderson, 1966, p. 15):

> 'To assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he (sic) would perform unaided if he had the necessary strength, will or knowledge

and to do this in such a way as to help him gain independence as rapidly as possible.'

If patients are in a continuous state of change they either recover, learn to live with their condition or move towards the end of life, and the nurse who is supporting them and providing their care must also be experiencing a process of continuous change.

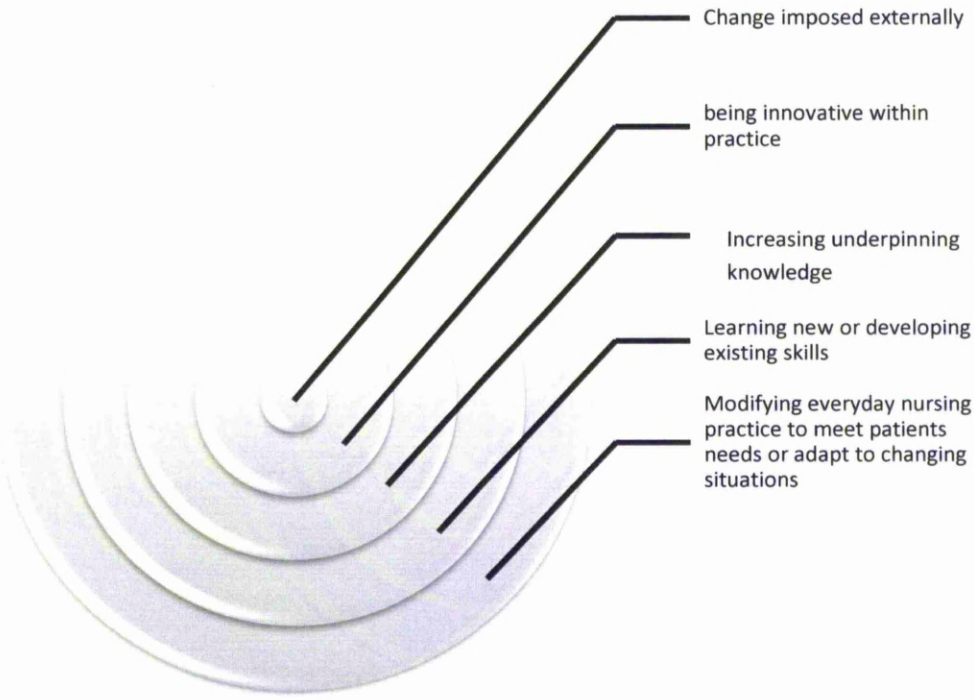

Figure 4: Hierarchy of practice change and development

This notion of nursing as being a process of change in itself was supported in this study and reflects participants' viewpoints of change. The most significant changes for participants, which form the base of the hierarchy, are the self-initiated incremental changes that result in improved patient care, arising from a need to cope with difficult situations, adjust and make sense of the experiences that they were having. Sometimes this resulted in a permanent change and at other times in a temporary adjustment that would then revert to the original care.

A relatively new way to describe nursing is that of bricoleur activity, with the nurse as the bricoleur (the bricoleur nurse) and practice as bricolage (Gobbi, 2005; T. Warne & McAndrew, 2008, 2009). The findings from this study on how practice changes can be explained by reference to Levi-Strauss (1966), an anthropologist who first defined the terms bricoleur and bricolage. However, there is limited literature on Levi-Strauss and the concept of bricolage as it relates to nursing practice. Existing research studies cited in the literature discusses the learning and development of nursing in practice with particular reference to nurses' use of intuition/reflection/ thinking in action (Gobbi, 2005); a second study addresses nursing as a bricoleur activity as a way of better understanding the inter-related connections between theory, nursing practice and the felt experience of service users (T. Warne & McAndrew, 2009). Research with patients, again using the concept of bricoleur, exists with one study of the ways in which cancer patients juggle with understanding and treatment compliance within the plethora of models of disease and therapeutic practices (Broom, 2009). Another study is a consumer account of responses to the third generation oral contraceptive controversy, and relates to bricolage and bodies of knowledge (Hester, 2005). The results from this study supported the notion of nurses as bricoleurs and the practice of nursing as bricolage. No literature was found that relates to how the concept of the nurse, as a bricoleur, relates to the personal process of practice change and development.

Nursing takes place within a complex context: a mental health nurse might have to practise within a context that is often uncertain, perhaps hazardous at times and distressing, for example with clients who commit suicide without any warning. Likewise, the nurse working on the acute ward may have to face lack of resources and shortage of staff, as well as distressing situations that are a feature of death and dying. The context within which participants work was significant to the mental health participants who discussed having to work within a new context, such as being in the clients' own home. They are also expected to function in multiple contexts, such as in a social environment as well as the professional environment of the healthcare provider organisation. Bricoleur nurses, or jack-of-all-trades, are regularly faced with the individual in their situated and concrete context of care,

and require a wide range of knowledge and skills to provide effective care. This knowledge includes the universal features of care, health, ill health and disease, as well as a specific knowledge of the individual (Gobbi, 2005).

Warne and McAndrew (2009) identify the nurse as a post-formal, or postmodern, bricoleur. The term postmodern is used as the nurse functions within contexts where truth and reality are individually shaped by the nurse's own personal and professional history, social class, gender, culture, and religion. These factors, according to postmodern thinking, combine to shape the narratives and meanings of our lives as culturally embedded, localised social constructions without any universal application (Edgar, 2006). Thus the nurse can be identified as a post-formal bricoleur, as one who 'draws upon a heterogeneous collection of fragments from multifarious sources which are then deconstructed and reconstructed in the context of working with the individual patient nursing' (T. Warne & McAndrew, 2009, p. 856).

This is very apparent in the role of the mental health nurse who works within a wide range of disciplines. The early intervention team, as an example, work within several frameworks, such as cognitive behavioural therapy, psychosocial intervention, family therapy, as well as having a working knowledge of housing and client benefits. As nurses working in the acute healthcare provider organisation, they have to develop these skills within their workplace which can be a ward environment, outpatient clinic or the client's own home, and they have to be resourceful. The role of the early intervention nurse can involve aspects of the roles of other professionals such as social workers – for example dealing with housing benefit – and they are expected to be teachers/health educators for which there might be minimal or no preparation other than learning on the job.

This study has identified that nursing practice has become an eclectic activity which is influenced by a wide range of factors. These factors made up the individuals' story or narrative of nursing, and though each nurse had their own story there are commonalities across the profession. Their story has developed over time and is made up of personal, cultural and professional influences brought forward from the

nurse's personal and professional history. These changes to their personal story of nursing are influenced by the experiences on a day-to-day basis, influences within the context in which they work, and their own personal identity and self-awareness.

Levi-Strauss (1966) identified these stories as myths which he says provide basic structures for the understanding of cultures. Myths are illustrated through language and reflect cultural values and sense of being, and they all include stories that provide meaning in order to make sense of the world and resolve cultural dilemmas (Wendy Doniger, 2009b; Kambouchner, 2009). Levi-Strauss suggests that myths are made up of multiple codes of which the original meaning or foundation has been lost (Wiseman, 2009). In nursing the elements or codes of the myth include skills, knowledge and beliefs that were learnt during their pre-qualifying period, as well as the rituals that are inherent throughout nursing.

One example that arose from the data was the nursing skill of aseptic technique. Initially the aim of the student nurse was to undertake the skill competently and safely, without knowing the underpinning theory. The nurse, after repeated practice and becoming more experienced, the need to know more than 'just how to do' the skill developed. When the time was right for the individual, they sought out the background knowledge from other specialists in practice, courses or programmes, or evidence embedded in policies or procedures. As time progressed, external influences added other layers of learning and a definitive policy was produced for this activity. The skill was then further influenced by the healthcare provider organisation which had controls in place to ensure compliance. Thus the story of the development of this skill, aseptic technique, has changed over time.

The narrative that develops does not always result in improved nursing practice. A further example that came from this study is of a qualified nurse who used one glove when administering an injection. The original skill would have been learnt as a student nurse and would not have included the need to wear gloves, unless there was a risk of a blood borne infection. The qualified nurse who was a role model wore one glove to administer the injection and he based his rationale on a Levi-Strauss 'myth' that he heard. This myth took the form of 'If you had a sharps

accident and it was your fault, then the NHS healthcare provider organisation would not support you.' This myth then became part of the nurse's story even though he acknowledged that it was not an example of best practice. The nurse developed the story further, despite knowing that the practice was unacceptable, by wearing a thinner glove so that the technique for injection giving was easier for him, and so demonstrated a behaviour which he knew was almost irrational.

Doniger (2009b) uses the metaphor of recycling to illustrate how myths change and develop according to the Levi-Stauss model. Myths are made up of units called mythemes, or codes reflected in language that over time get broken, put together again or recycled. It is the bricoleur, or handyman, who puts these mythemes back together to create a new story. This new story is termed the bricolage. Examples of mythemes from within the data include the expectation of nurses and doctors to provide patients with enough information to be able to make an informed choice in their treatment and care. This leads to the provision of information to patients that is sometimes counterproductive: for example, in the ophthalmology clinic this led to very anxious patients and nurses having to amend their care in order to spend time calming patients down before they could perform the necessary procedure.

A further example of a mytheme relates to nursing rituals. Nursing rituals (see chapters two and six) can be distinguished from traditional rituals, though both exist in nursing. Nursing rituals are nursing practices that are routinised and have no underpinning theoretical basis (F. Strange, 2001a). Traditional rituals, however, have several purposes including reducing anxiety and distress, responding to death and dying, and promoting values within the society of nursing (Lee, 2001). Nursing rituals are an example of a mytheme that make up the bricolage of nursing. The message that participants gave during the interviews was that these rituals were poor practice and no longer a part of nursing. In reality, however, several examples of nursing rituals were given, all linked to practice that involved task allocation and without obvious awareness of the implications. The method of application of compression bandages was cited as one ritual that had been consciously discontinued from nursing care. Previously, during the procedure the nurse would go round the ward, bed by bed, using the same trolley and applying the bandages

to the patients. Nowadays, the more acceptable practice cited is to maintain the task allocation aspects, but to wash the trolley down between patients. This mytheme has been discontinued in the eyes of the nurse who described the practice, but in reality the mytheme of the task allocation ritual is too strong to be totally eradicated, resists change in practice, and exists within practice in an amended form.

8.1.1 Skill and knowledge development

This study found that knowledge that underpinned practice for the bricoleur nurse came from a range of sources. The least referred to was the empirical or evidence based knowledge: only two participants actively sought out research/evidence to inform their practice. Participants tended to see new empirical knowledge as something that they passed on to novices or students, as opposed to something that they would use to underpin or change their own practice.

When the participants were exposed to a disciplinary knowledge base such as sociology or psychology, they learned it as a bricoleur, acquiring enough knowledge to apply what they needed to the situation at the time, or they learned as a scientist who applies the lens of the discipline to practice without any impact on practice (Gobbi, 2005). For the bricoleur nurse, this disciplinary knowledge becomes one of the tools available when needing to make clinical decisions.

Educational programmes were viewed by participants in conflicting ways. Some were valued; others were necessary for taking on new roles, but not valuable in their own right or a reason to change practice. Educational programmes that were valued were those that provided knowledge, combined with the opportunity to practise and develop skills and work with a mentor. In one instance the relationship with the mentor continued as clinical supervision once the programme was complete. Other participants saw no reason to undertake educational programmes as they could not see the value in terms of their practice.

Participants identified that they are constantly learning new skills, or developing existing skills, over time. This was particularly pertinent to the EIT members who

very often joined the team with no prior experience of this way of working, and had to develop skills in working with clients using cognitive behavioural therapy, family therapy and psychosocial interventions. These participants often had to develop and use these approaches and skills of varying frameworks without any formal educational background or support. The skills that the champions highlighted included offering triage telephone advice within ophthalmology, surgical pre-operative assessment and managerial skills.

Participants constantly had to develop new skills that were associated with the developing and changing bricolage within the context of their workplace. These skills may not necessarily be those that would normally be associated with nursing: for the early intervention nurse they could include teaching skills; handling groups of young people, who are the unwilling participants of the teaching session; assisting in social issues such as housing and benefits, which is classically seen to be the role of the social worker; and developing skills in lone working.

Nurses as part of their everyday practice both metaphorically and literally handle people, and can be identified as 'embodied bricoleurs' (Gobbi, 2005). When participants are caring for patients they are drawing upon a range of knowledge and skills which include reading the signs from the patients, their body, referring to what they know about the situation in hand, what they are hoping to achieve, and what they have available from previous situations, and then deciding how to respond through their own bodies and their own self (Gobbi, 2005; Hester, 2005). Consequently, nurses always to some degree put something of themselves into their nursing practice. This results in an embodied bricolage and the development of embodied knowledge which is a product of their overall actions. This embodied knowledge is the intuitive, subjective knowledge that they refer to in order to make sense of their practice. It is knowledge that is interpreted through their self-awareness and experiences that they have had in practice. Embodied knowledge is initiated through feelings arising from experience that something they are doing is not right, through watching others, through knowing that their approach is not the right one, and looking back on how they handled situations in the past, all of which lead to a general awareness of wanting to change. They become 'conscious, aware

and informed by putting something of themselves into the activity' (Levi-Strauss, 1966, p. 21). As Benner observed 'Our embodiment is a unity that we live, therefore we do not perceive the world in pieces or meaningless sensations, but as a whole pre-given, pre-reflective world' (Patricia Benner, 2000, p. 6). Participants' embodiment is influenced by their own personal values, which can come from various sources, including religious frameworks, and personal or family experience of ill health, and these can lead to an increase or decrease in empathy with patients. Other influences that may impact on embodied knowledge include gaps in knowledge, cultural and professional perspectives, significant others who act as role models, or clinical or managerial supervision.

Bricoleur nurses with their tools do not create new knowledge, as in empirical knowledge, but create new understandings or an assemblage of existing knowledge that they use in their practice (Hester, 2005). These new understandings are the knowledge that is generated in practice, or clinical expertise (Winch, et al., 2005). The nurse, who for years had been making beds by top and tailing the sheets, suddenly had a realisation that her practice was unacceptable (to herself) and she needed to change. This realisation was new embodied knowledge based upon her feelings on putting the part of the sheet that had been near the patient's feet up to his or her face when 'top and tailing' the bed. She put herself in the place of the patient, instantly changed her practice and shared this new understanding with her nursing colleagues.

Hester (2005) suggests that disembodied knowledge, such as evidence, statistics and scientific information are filtered through the individual's body along with embodied knowledge in order to create new understandings. Hence, the bricoleur nurse uses a wide range of knowledge – scientific, contextualised, personal knowing and patient experience knowledge – in the provision of patient care (T Warne & McAndrew, 2005).

The process of creating new knowledge or new understandings has been identified within the literature as the process of reflexivity (Fook, 2007). Reflexivity is the ability to look inwards and outwards using a process of reflection, and recognising

the significance of wider social and cultural influences on the process (S. White, 2002). All aspects of ourselves and our contexts influence the way we create new knowledge, either through research or practice (Ruch, 2002). Knowledge creation is therefore 'reactive, embodied, social and interactional' (Fook, 2007, p. 31). This embodied knowledge is influenced by the individual, their past and current experiences, their senses and the situation at hand. Knowledge creation is reactive as it is influenced by the tools and processes that are available; an example being the differences in knowledge that will be generated by a mental health nurse who uses an assessment tool as opposed to one who has no framework to use. Knowledge according to Fook (2007) is also interactional in that it is shaped by the historical and cultural contexts within which it is generated.

Clinical supervision is one of the frameworks where this process of knowledge generation is facilitated. The supervisor and supervisee share their own experiences and knowledge as applied to specific situations. One participant was struggling with a patient who was suffering from severe acne and social phobia, and who was reluctant to leave his house. As part of this supervision it became apparent that the patient's medication was likely to be the cause of the acne, and the sharing of this knowledge led to a change in practice and an improved outlook for the patient.

8.2 The personal process of practice change and development

8.2.1 Experience

The personal process of practice change and development was identified in the study as a process that centres on the experiences that participants have in their workplace. The participants need to make sense of this experience. Factors that impact on the sense making process include existing knowledge that underpins their practice and any gaps in that knowledge. This knowledge is predominantly experiential knowledge as opposed to techno-rational knowledge. Other influences include support from professionals who are valued in practice (particularly in relation to filling in any gaps), participants' own personal values, the culture or role of the organisation, and the support offered within their professional culture. They then make a judgement or decision that involves an interweaving of factors which

lead to either a change or continuation of current practice. The following section of this chapter will explore this personal process of practice change and development.

All nurses have their own individual stories or narratives of nursing practice which develop and change as they have further experiences over time. Their stories are influenced by their experiences and values, both personal and professional. These values may come from the professional culture of which they are a part, and may include beliefs that do or do not relate to best practice. Examples include aspects of nursing rituals which participants may or may not recognise as making up part of their own practice. Other influences that have developed the individual story are personal values such as their religious frameworks, and personal experiences such as having suffered from depression or having a close relative with mental illness, which leads to experiencing the service from the 'other side' as a client and recipient of services.

This study found that the foundations of the bricolage of nursing practice are predominately made up of experiences that participants have in the workplace. The experiences that participants described were either directly or indirectly patient/ client based and make up a substantial part of their daily practice. As can be seen from chapter five, these experiences can be positive, difficult, distressing or dangerous, and imposed by external bodies, national government or the healthcare provider organisation within which they work. Participants were not always able to control how or when the experiences occurred, nor their reactions to them. They also recognised that experiences accumulate, leading to them becoming progressively more experienced.

Within these experiences are signs and signifiers. Signs 'are categories that indicate something else, whether it is an object, a state of affairs or a belief' (Gobbi, 2005, p. 119). Signifiers are the representations of these signs that identify meaning, such as crying, laughing, and signs of distress. Examples of signs from within this study included physical signs such as escalating patient aggression; poor wound healing, anxiety during procedures, and test results such as haemoglobin blood measurement. Levi-Strauss (1966) suggests that signs are somewhere between

images and concepts: 'Signs resemble images in being concrete entities, but they resemble concepts in their power of reference' (Levi-Strauss, 1966, p. 18). The participants identify signs, at a conscious or unconscious level, and use their meaning as part of the sense making process. These signs or cues in the environment are some of the properties of sense making (K E. Weick, Sutcliffe, & Obstfeld, 2005).

8.2.2 Sense making

Sense making is an approach that involves a process of interpretation and meaning-making that results in making sense of events (Brown, Stacey, & Nandhakamur, 2008). Sense making comes into play when unforeseen experiences or events challenge the participant's existing story of nursing. The participants are subject to numerous experiences and challenges within the context that they work, and have to make sense of these events and the potential impact on their practice, before deciding whether to make a permanent change or not. Weick (2001) states that sense-making involves constructing meaning from data that are sometimes puzzling and troubling. Thus, sense-making is an 'iterative process whereby individuals actively collect together varying forms of expertise, practices and technologies in an attempt to create [a] subjectified, "individualized and embodied therapeutic trajectory"' (Broom, 2009, p. 1052).

The bricoleur nurse is required to undertake practical problem solving as part of everyday practice. A metaphorical toolbox is available to the nurse in order to enable this problem solving. Pre-existing tools and knowledge are then reconstructed and reworked to solve the problem at hand (Broom, 2009; Hester, 2005). Very often the available tools 'bear no resemblance to the current project' (Levi-Strauss, 1966, p. 17) because they are derived from participants' personal biographies. According to Hester (2005, p. 84), 'the bricoleur links materials and information in the present to specific knowledge accomplished in the past and anticipations in the future.'

Tools available to participants include differing therapeutic methodologies such as psychosocial interventions, cognitive behavioural therapy, family therapy and pre-

existing assessment tools. The bricoleur nurse will use whatever tools or resources are available at the time, which may include other professionals and their expertise. Knowledge can also be a part of this metaphorical toolbox, and is sometimes actively sought from others within the organisation such as specialist nurses, and at other times provided by the organisation in the form of training and development sessions. Other tools include clinical supervision for the EIT, information from programmes and courses, clinical products that are available to the participant, past experiences that have been good or bad, and evidence that is sought or provided. Further tools include protocols or processes that are expected to be used by the healthcare provider organisation, and the results of audits undertaken within their practice area.

Other ways of making sense include trial and error, trying out new approaches, being flexible, watching others, and picking up good and bad habits. Trial and error is an example of enactment which is one of the properties of sense-making; people do not wait passively for things to happen, but act to influence the environment and observe what happens (K E. Weick, et al., 2005).

Weick (2001) identifies further properties that characterise the on-going process of sense-making. Firstly, sense-making is grounded in identity construction. How the sense maker interprets what is happening depends on who they are, their personal values, and support or threats within their own settings. In this study, one participant had a brother with mental health problems and discussed how the first-hand experiences of mental health services impacted on his provision of care, making him more sensitive to the needs of his own clients and seeing the experience from the 'other side'. Another participant, a practising Catholic, thought she had to be aware of the conflicts between her religious framework and that of others, such as when she was caring for Muslim men.

An important part of sense-making, as identified by Weick (2001), is retrospection as individuals use hindsight to look back in order to reflect on previous experiences. Participants recognised that they used the process of reflection on practice in order to make sense of events that had taken place (Schon, 1983; Sudi & Michael, 2009).

The majority identified the process as happening, often at the end of the day on the way home.

Clinical supervision is an integral part of mental health nursing and the majority of mental health participants had access to supervision, either management or personal supervision. For the majority of participants this process was seen as beneficial, and a clear example of how supervision facilitated practice change was identified. Although none of the participants could identify a structured process for supervision, generally it was seen as a process for helping them to manage and make sense of their caseloads which contributed to changing practice.

One aspect of sense-making is that groups of like-minded individuals such as nurses will see and understand actions and experiences in similar ways (Bean & Hamilton, 2006; Sackman, 1991). These shared understandings, according to Bean and Hamilton (2006), are described as frames of reference. This framing is a way of managing meaning by being selective and highlighting some issues over others. Frames also delineate boundaries around the issues that need to be made sense of. Participants identified shared frames of reference in response to change that was imposed on all the team at the same time. The implementation of a new risk assessment form that was viewed as not totally appropriate for the speciality, and which would unreasonably increase participants' workload if it was completed as required, illustrates this shared frame of reference. A manager enabled the team to make sense of the form through discussion at team meetings, seeking information from other teams as to how the issue was being dealt with there, and coming to a shared agreement on how the form could be completed in a manner that did not compromise the healthcare provider organisation or the team's requirements. This notion of a shared frame of reference also highlights that sense making has a social dimension (K E Weick, 2001)

8.2 3 Changing or not changing practice

As stated previously in this chapter, the participants are faced with a multitude of experiences as part of their everyday working life. Following the sense making process, participants then have several options, some of which include amending

their practice and reverting to the original practice once the situation is over, or making a permanent change.

Three processes were referred to by participants that related to the decision to change or not change practice: intuition, learning and reflection. Participants clearly identified learning as a process of change and although they did not refer directly to intuition, there were clear examples of the intuitive process as a starting point for change. Participants also referred to reflection as part of the change process. One participant summarised the process of change as 'developing, learning, reflecting, moving on and changing'.

The process of intuition was referred to by participants as an awareness of how they engage with clients, as the following examples from the data highlight: 'something that you develop or is just part of you, just something you become', and 'feeling that something is not right, or a sense that you like an approach that is seen in the work of a colleague'.

Part of the process of intuition as applied to nursing is based upon experiential learning, perception, embodied skilled know-how and recognition (Patricia Benner, 2000). One definition that sums up the process of intuition is 'the understanding without rationale, inherent in the expert practice of operating from a deep understanding of the whole situation' (P Benner, 1984, p. 32). This intuition is a balance between knowledge, expertise, and experience, and has been applied to nursing practice as part of clinical decision making (McCutcheon & Pincombe, 2001; Traynor, et al., 2010; Welsh & Lyons, 2001). This type of decision making is cited in response to everyday practice where nurses encounter situations that require early warnings or recognition that something is not right. These include ambiguous situations when there is a need to react to situations instantly.

The main focus of all intuitive decision making models in nursing suggest that intuitive judgement distinguishes the expert from the novice, with the expert having developed skills that mean they do not need to analyse situations before they act (Thompson, 1999). Intuition was a feature of all but two of the interviews with nurses within this study. Two participants did not allude to any form of

intuition; one was newly qualified and the other very experienced over a number of years. Both relied heavily on protocols and frameworks to guide their practice. Only one participant could be referred to as an expert, which has been defined as having at least five years' experience and acknowledged by peers and supervisors as an expert practitioner (Billay, Myrick, Luhanga, & Yonge, 2007). Despite this, the majority of participants identified intuition as an integral part of their practice change and development.

Although this study has recognised that intuition is an important feature of the process of practice change and development, it is not possible to elucidate this concept without further research. The remainder of this chapter will comment upon the role that intuition plays in the overall process of practice change and development, as opposed to giving an in-depth analysis of the nature of intuition.

The second process referred to by participants was learning. This aspect was highlighted as learning from experience and phrases such as 'being on a learning curve,' constantly learning', 'learning over a period of time' and 'learning on your feet' were highlighted by participants. This learning arose from experiences that were encountered within practice, and often these experiences were difficult and challenging, caused uncomfortable feelings and led to the desire to change.

Experiential learning has been defined as 'having one[']s expectations refined, challenged or disconfirmed by the unfolding situation' (P. Benner, Hooper-Kyriakidis, & Stannard-Daphne, 1999, p. 568), is based upon how individuals process experience (Boud, Cohen, & Walker, 2000; Fowler, 2008) and involves the process of reflection (Rashotte & Carnevale, 2004).

Learning from experience underpins adult learning (Kolb, 1984; Miettinen, 2000; Yorks & Kasl, 2002), and is often related to promoting learning within the workplace (Dewar & Walker, 1999; Mezirow, 1998) and work based learning. Miettinen (2000) suggests that the founding fathers and developers of the concept are David Kolb, John Dewey, Kurt Lewin and Jean Piaget. The classic experiential learning process developed by Kolb (1984) constitutes a four stage learning cycle that learners undergo. The learning commences with a concrete experience, which then leads to

reflection on the experience. As a result of this reflective observation, abstract concepts are devised to serve as frameworks for future actions. The frameworks are actively tested in new situations, leading to new learning that can then be applied to the next experience (Baker, Jensen, & Kolb, 2002).

This model of experiential learning hinges on the experiences that the learner has in practice and the process of reflection. The majority of participants identified that they considered themselves to be reflective and that they regularly reflected upon their nursing practice. For the majority this took place after the event or the experience, and could be identified as reflection on action (Schon, 1983). Several participants saw this reflective process as a means of getting their practice into perspective and as a form of stress reduction. They all identified a similar reflective process which was summarised as 'what went well, what didn't go well, and what is the learning in the situation' (B1a). There was no acknowledgment of reflection in action (Schon, 1983), which does not mean that it is not taking place, but that the participants were not aware of the process.

However, this study has identified that learning for participants also takes place without reflection. Although professional learning was seen to centre around experience, there are also strong influences from the complex context within which practice takes place, personal, professional and cultural influences that the participant may be unaware of and unable to verbalise, and that are not accounted for within Kolb's model. Likewise, learning sometimes arises from repetition and the everyday habitual processes of life, and at other times from intuition and intuitive thought. Miettinen (2000) suggests that this non-reflective experience born out of habit was the dominant form of experience, and that reflective experience only occurred when there were contradictions of the habitual experience. This was the basis of experiential learning as identified by Dewey (1997) which Kolb does not discuss in his model. Dewey also believed that observations of reality and nature were the starting point of knowledge acquisition, whereas for Kolb the starting point was experience (Miettinen, 2000).

This study has supported the notion that emotions, embodied feelings, sensory motor perceptions and skills shape rational thought and actions (P. Benner, et al., 1999; Lakoff, 1999). It is embodied knowledge that contributes to the overall perception and understanding of the situation, and is an integral part of experiential learning that participants identified as the main component of the process of change. The process of practice change and development as identified in this study is an integration of embodied experiences, knowledge, reflexivity, reflection and experiential learning within the context of practice.

The process of practice change and development was identified by one participant as developing and learning, reflection, moving on and changing. This can be demonstrated by the following example: evidence suggests that best practice in the use of topical steroids for skin diseases is the use of only fingertip measures on the skin. But knowing intuitively, from embodied experience and knowledge, that for some conditions steroids are ineffective at low doses, the participant used embodied experiences and knowledge as tools within the decision making process. The outcome was that the steroids were used at high doses as needed, were reduced quickly, and ceased to be used on completion of treatment.

8.3 Practice change and development

The findings that emerged from the study were amalgamated and presented as a Practice Change Model (see figure 10). The model shows practice change as a continuum, and highlights how participants respond on a daily basis to personal practice change and development within the context of their own workplaces. These responses cover both day to day changes, and changes in practice imposed on participants. The model embodies four approaches to practice change and each approach describes participants' response to change, willingness to change, and the work contextual influences within their own context to implement change in practice. In previous chapters, these responses were labelled as four approaches; as the theory is now developed, each category of response will be given a name that describes their response to practice change and development.

The use of a continuum is based on recognition that not all individuals respond similarly in certain situations, that there are a range of responses, and that individuals may move up and down the continuum according to their stage of development. The top of the continuum is seen as the most desirable state, as it involves a greater degree of critical analysis of contextual factors, self-awareness, and characteristics of the individual that are thought to lead to care that is better informed. The bottom of the continuum is the least desirable as this involves less critical thinking in response to practice change and the most habitual nursing practice. It was noticeable that participants fell mostly into one category for the majority of the practice that they discussed. There were, however, some contradictions: the one participant who had undertaken research into practice also identified clear ritualistic practice without realising it.

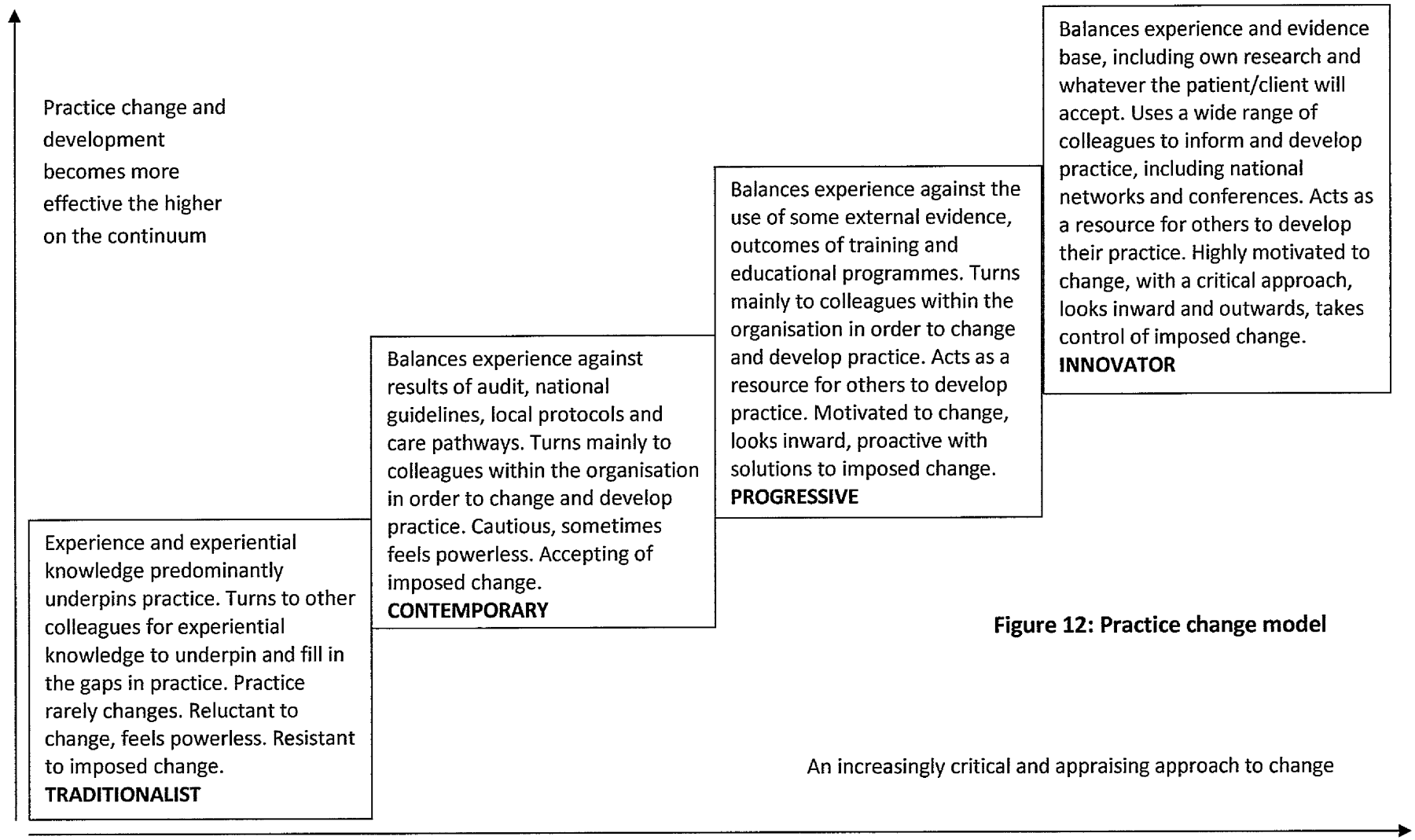

Figure 12: Practice change model

All participants related their practice change to workplace experiences. Bricoleur nurses have access to a wide range of resources within their metaphorical toolbox that they then balance against their embodied experience to make sense of nursing practice and change. The continuum identified the range and variety of resources that the participant would most commonly use in decision making for change. The innovators at the top of the continuum actively sought and referred to a wider range of resources, such as looking externally to research reports, conference presentations, best practice in others and audit, to inform their practice and judge potential for change. Traditionalists, at the bottom of the continuum, only referred to resources within their immediate environment, including other colleagues who provide experiential knowledge to underpin and fill in the gaps in practice. The majority of participants fell into either the 'progressive' or 'contemporary' categories. Contemporaries referred to evidence that was embedded within protocols, clinical guidelines and frameworks that arose from national agendas, such as the National Service Frameworks for Older People (Department of Health, 2001b), which were imposed on them by the organisation within which they worked. Progressives used a wider range of evidence, which included outcomes from programmes and courses that they attended. The programmes that were identified as contributing most to practice change were those where a mentor was allocated and support provided in skill development. Only two of the participants were innovators and regularly sought evidence externally to underpin practice and use in decision making for change. Only one participant had undertaken empirical research in practice.

As nurses, participants have been educated and socialised to maintain their ontological security, which is reinforced by the national evidence based agenda and subject to review and audit (T. Warne & McAndrew, 2009). NHS organisations also reinforce this agenda through the requirements to adhere to guidelines and protocols as part of clinical effectiveness (Mead, 2000). To step outside this ontological security (or comfort zone) leads to an unconscious challenge to emotional homeostasis and sense of self (Laing, 1960). This study found that participants' ontological insecurity could be influenced by the extent to which they

are prepared to take risks and move out of their comfort zone. Participants at the top of the continuum were more able to accept ontological insecurity and seek out a wider range of evidence to refer to as part of their metaphorical toolboxes, whereas those at the bottom were more reluctant.

This ontological insecurity also reflected on participants' responses to change in practice. Traditionalists were reluctant to change, felt powerless and were resistant to imposed change. Innovators, at the top of the scale, were willing to take more risks and this was reflected in their response to change. They were more confident, acted as a resource for others to develop their practice, and used a critical approach when deciding whether to implement a change or not. Contemporaries used protocols, guidelines and national frameworks as a means of maintaining their ontological security, not having to take any risks by seeking any further resources, and were accepting of imposed change. Progressives were willing to take more risks by referring to external evidence, challenging their practice more and acting as a resource for others.

The continuum also comments upon participants' level of expertise in practice. All but one participant were 'experienced' as defined by Arbon (2004), though only two participants could be counted as experts according to Benner's work (P Benner, 1982). One definition of an expert is 'one who no longer needs to refer to the rules of practice as they had become rule makers of practice' (Lyneham, Parkinson, & Denholm, 2008, p. 386). This study found that when changing practice an expert nurse refers to a wide range of knowledge and epistemologies taken from a number of sources, balances all of these factors to come to an informed decision, and collates and translates them into their own practice in accordance with their own needs and subjective experience of nursing practice using an embodied intuitive process.

Two participants in this study, the traditionalists, could be described as 'novice' as identified by Benner (P Benner, 2001), and the 'contemporaries' and 'progressives' could be identified as competent or proficient, again according to Benner. Those in the middle, contemporaries and progressives, were more likely than the

traditionalists to take risks, but tended to stay within their comfort zones in relation to change and development. They looked inwards towards colleagues in their workplace to fill in gaps in knowledge, and relied mostly upon protocols and other healthcare provider organisation guidelines to facilitate their nursing practice.

This study found that increasing experience does not necessarily lead to increasing expertise in response to practice change and development, which is the basis of Benner's work (P Benner, 2004). The majority of participants had been qualified for over five years, yet some could still be identified within the competent and proficient stages. Becoming experienced is not a linear process (Arbon, 2004). As can be seen previously in this chapter, nursing is an existential and embodied process that is influenced by a wide range of factors, including the context within which nursing practice takes place. Benner's linear model does not fit with the experience of nurses, and does not reflect the complex understandings that nurses have about their practice across fields, or in differing circumstances and with different people (Arbon, 2004).

8.4 Resistance to imposed change

Resistance to self-imposed change of practice within this study has been described earlier in the chapter; it could be re-defined as reluctance to change and is a feature of ontological insecurity. Resistance to imposed, top down change, however, is perceived in the literature as something that has to be resolved as it impedes the implementation of change (Copnell, 1998), and is often discussed from the perspective of the manager or change agent implementing the change (Balogun, 2006). Likewise, resistance to change is mostly reflected within the literature as a response to imposed change (Pardo de Val & Fuentes, 2003; Waddell & Amrik, 1998). Much of the literature on resistance to change addresses resistance during times of major organisational change (Bovey & Hede, 2001a; Elrod & Tippett, 2002; McPhail, 1997), and there is limited literature on the manifestation of resistance to change in clinical practice development which is the subject of this thesis (Copnell, 1998; Copnell & Brunei, 2006).

Many of the frameworks of nursing care have historically been imposed on participants either by the organisation within which they work, the government, or a statutory body. Examples from within the data include specific patient and risk assessment tools, and care planning documentation for the Early Intervention Team. The acute healthcare provider organisation had a culture of using clinical audit to implement change, and also worked with a range of patient assessment tools which adhered to national guidelines that had been imposed on participants as part of their frameworks of care.

Imposed change to practice within this study is that applied by the organisation, the government or statutory body, and usually involves a change agent identifying strategies for planning and implementation. This type of change was the least referred to during the interviews. Participants were asked to cite examples of how they believed that their practice has changed and to identify influencing factors, and few participants initially identified top down, imposed change. As a result a further set of interviews was conducted to explore this issue, and examples were elicited. This lack of awareness suggests that imposed change was of less significance to participants than the changes that they instigated themselves, which were freely discussed.

Several participants discussed the implementation of electronic care planning as an example of an imposed change. Their initial response was concern and anxiety as they tried to fit the new practice into their existing frameworks. This was based on the notion of the social view of change (J. Ford & Ford, 2009) in that individuals' response to change, both imposed or self-generated, was similar to their responses developed to everyday life events. Implementing new practice led to ambiguity (K E. Weick, et al., 2005), as the new practice did not necessarily have a shared frame of reference amongst participants and conflicted with existing structures within the bricolage of practice. Examples of these concerns included lack of information for participants on the substance of the change, unacceptable decision making processes taken at a higher level, inadequate training and lack of follow-up support. This latter point was a common reaction in response to the implementation of electronic record keeping across the healthcare provider organisation. Some

participants had minimal computer skills, felt the training provided was rushed and incomprehensible, and then had no real access to support once they were using the system in practice. Initially, concern and anxiety were the identified responses to imposed change as participants sought to make sense of the contradictory frameworks. Participants needed to create new frames of reference in these ambiguous situations in order to reduce the ambiguity, make sense and develop new meanings in order to bring the *status quo ante* back into their lives. Imposed change conflicted with nurses' own bricolage and there was evidence that the imposed care was amended in order to fit into an acceptable norm. Generally, small strategies were developed to get round these problems and included devising standard patient care plans, seeking similar examples from the past as a model for moving forward, and gaining support from other team members who were perceived as having better IT skills.

Imposed change, however, can often lead to unanticipated outcomes and unintended consequences, both positive and negative (Balogun, 2006). There were clear examples of unintended outcomes of change identified within this study. These included one participant devising and recording standardised templates for care planning as opposed to recording actual care given. Another unintended outcome was duplication of work, as participants made paper notes of care before recording the details electronically.

8.4.1 Barriers to research utilisation

One further aspect of resistance to change that dominates the literature on nursing practice is that of promoting the use of research and evidence based practice, and identifying the reasons that it is not extensively used (Purkis & Bjornsdottir, 2006). The aim of the evidence based practice movement is for nursing practice to be based upon the best available current, valid and relevant evidence. There is an extensive core of literature on barriers that exist to nurses' use of research and evidence within their practice (McCleary & Brown, 2003; Kader Parahoo, 2000), and this was summarised in the literature review. This literature takes a technical-rational view of nursing practice in assuming that quality assured nursing care and

healthcare delivery can only be achieved through adherence to evidence based guidelines and protocols (Fish & Coles, 2002). This approach rejects the notion of professional practice as artistry and has formal theory at its core, with 'theory being more valuable than practice and that practice is merely a vehicle for putting into operation formal theory' (Fish & Coles, 2002, p. 44).

The use of evidence based practice and research was identified in Chapter 4. Evidence based practice and the use of research were not identified as guiding principles to the nursing practice of the majority of participants' for either team. Only one participant identified any personal research undertaken and just two referred to research in the development of protocols. The culture within the organisations of the nurse champions relied heavily on protocols and guidelines to inform practice and these have an automatic evidence base, which is developed externally rather than locally. Likewise, the EIT advertise their service as a specialist mental health service offering intensive evidence based support to individuals aged 14–35 experiencing a first episode of a psychotic disorder, suggesting that evidence was embedded within their processes and systems, and participants recounted that this was the case. The reluctance towards the use of evidence based practice or research, highlighted within the literature, is not seen here, which suggests that within these services the processes and systems are based on evidence, and are embedded into the culture of the organisation and the participants' everyday work. They are not seen as extraordinary or something to be resistant to.

One study that related to change of nursing practice was undertaken by Copnall (1998) as part of PhD research during which twelve critical care nurses' understanding of change in their practice was explored. Participants taking part in Copnall's study struggled throughout the interviews to identify practice changes for discussion, which they attributed to a memory lapse or the change being normalised into everyday practice. Copnall and Brunei suggested 'new practices are normalized over time, becoming equally taken-for-granted as the previous norm, yesterday's innovation is today's routines' (Copnell & Brunei, 2006, p. 304). There is evidence to support this finding within this study. Changes that are imposed can be

embedded into participants' bricolage and become part of their everyday practice, and are no longer recognised as significant.

8.5 Summary

This study has supported the view that nursing can be defined as a process of change in its own right, both for the nurse and the patient, and that nursing practice reflects participants' viewpoint on change. Nursing practice has been described in this study as a bricolage with the nurse as a bricoleur. For the bricoleur nurse, her practice has become an embodied, eclectic activity, which is influenced by available resources or tools and by historical and cultural contexts. This study found that knowledge that underpinned practice for the bricoleur nurse came from a range of sources which included other colleagues, experiences in practice and clinical supervision.

The study found that nurses understood the process of practice change as a hierarchy with the most significant aspects of practice change at the bottom. These were the day-to-day changes that may or may not lead to permanent change. At the top of the hierarchy and of least significance to participants were the changes imposed by their employing organisations or nationally. The personal process of practice change and development was identified in the study as centring on the experiences that participants have in their workplace, a process of sense making, learning and intuition.

A model of practice change and development, the Practice Change Model, was developed in the form of a continuum that described how nurses respond to change and development, both day-to-day and imposed from above.

CHAPTER 9

CONCLUSIONS, IMPLICATIONS OF FINDINGS AND RECOMMENDATIONS

9.0 Introduction to the chapter

This final chapter of the thesis will address the conclusions that have arisen from the research, their significance, and the implications for practice change and development in nursing. Limitations of the research will be discussed, and recommendations for promoting practice change and development in nursing and possibilities for further research suggested.

9.1 Implication of the findings of the study

The purpose of this study was to investigate how nurses' practice changes and the process that they go through as they change their practice. The process of change and development of practice has been identified as a changing or developing bricolage – a piece of work that is constructed from different resources – with nurses as the bricoleurs. It is this changing bricolage that participants' are seeing as their change in practice: the bricolage changes as the situation changes, according to the patient/clients' needs, the nurses' understanding of themselves and the clients, the resources that are available and the underpinning knowledge.

The area of concern for a manager is how to effectively implement new practice that has an evidence base, whereas the concern for the nurses themselves is to be enabled to provide effective nursing care to their patients. Consequently, these recommendations will be presented from a range of perspectives: the nurse who is changing practice; the nurse manager who designs and implements change of practice; the educator who runs programmes at both pre and post registration levels; and, at a nation level, for the government and statutory body who specify change.

9.1.1 Promoting change of practice on a day-to-day basis

The study found that nurses understood the process of practice change as a hierarchy with the most significant aspects of practice change at the bottom. These

were the day-to-day changes that are modifications or adaptations of practice that may or may not lead to a permanent change. These changes were identified by participants as the most significant type of change impacting on their professional practice. This type of change was also the most highly valued and was seen as being the most influential.

The findings of the study supported the view that nursing can be seen as a process of change for both nurses and patients. This meets the description of nursing identified in the literature review: promoting an ongoing process of change for the patients and their relatives (Hussey, 2002). This suggests that change is inherent in nursing and happens continually. The nurse who is supporting and caring for the patient, therefore, must also be experiencing continuous change.

Further findings indicate nursing practice has become an eclectic activity which is influenced by a wide range of factors. These factors constitute the individual's 'story' or 'narrative of nursing'. This story has developed over time and is made up of personal, cultural and professional influences brought forward from the nurse's personal and professional history. These changes to their story of nursing are influenced by their experiences on a day-to-day basis, influences within the context in which they work, and by their own their own personal identity and self-awareness. This study found, however, that increasing experience does not necessarily lead to increasing expertise in response to practice change and development.

This study has supported the notion identified by Benner et al. (1999) that emotions, embodied feelings, sensory motor perceptions and skills shape rational thought and actions. It is embodied knowledge that contributes to the overall perception and understanding of the situation, and it is an integral part of experiential learning that participants identified as the main component of the process of change. The overall process of practice change and development as identified from this study is an integration of embodied experiences, knowledge, reflexivity, reflection and experiential learning within the context of practice.

The literature defines practice development as an 'interconnected and synergistic relationship between the development of knowledge and skills, enablement strategies, facilitation and a systematic, rigorous and continuous process of emancipator change in order to achieve the ultimate purpose of evidence-based practice person-centred care' (McCormack, et al., 2004, p. 29). There are overlaps between the findings of this study and work on the nature of practice development. These areas of overlap are the recognition of the significance of workplace experience, personal values and beliefs, and the influence of work- based culture on practice change (Manley, 2004; Shaw, et al., 2008).

Nurses are bound by their professional code of conduct which states that 'care delivered must be based on the best available evidence or best practice' (Nursing and Midwifery Council, 2008, p. 6). The implication from this study is the need for the identification of effective strategies for promoting, supporting and enabling the process of practice change and development, both from the managers' perspective and that of the nurses in practice.

Challenges for healthcare organisations in promoting practice change and development are that these changes are contextually bound, found at the micro system level of care, and involve a series of interventions based upon a range of methodologies (Manley, McCormack, & Wilson, 2008b). Findings from this study also suggest that top down approaches are not always the most effective means for implementing practice change. Thus, effective promotion of practice change needs to take into account all of these factors, including bottom up as well as top down strategies, skilled facilitation and enablement of person-centred care.

9.1.2 Promoting the process of practice change and development

Three processes were referred to by participants that relate to the decision to change or not change practice: learning, intuition and reflection. Learning from experience and phrases such as 'being on a learning curve', 'constantly learning', 'learning over a period of time' and 'learning on your feet' were phrases that participants used to describe the process of change. Although learning was seen to centre on experience, there are also strong influences from the complex context

within which practice takes place, including personal, professional and cultural influences that the participant may be unaware of and unable to verbalise. The implication for nursing is that if practice change and development is to be promoted, then learning from practice needs to be an integral part of the strategy.

This learning was not necessarily linked to credited programmes, but formal learning that was valued usually related to skills and involved support of a mentor in the workplace. Therefore, in order to promote a change in practice nurse managers need to consider strategies that promote learning and are embedded into workplace practices (Scheeres, Solomon, Boud, & Rooney, 2010). Learning at work is not a new concept and terms such as learning organisations (Senge, 1990), curriculum connectivity (Guile & Griffith, 2001), workplace pedagogy (Fuller & Unwin, 2002) and everyday learning (Boud & Solomon, 2003) all describe the notion of learning through work.

The literature discusses active learning as one of the most significant influences on practice development (McCormack, et al., 2009). Active learning is described as engaging and learning from personal experience and includes critical reflection, learning from self, learning from dialogue and learning from shared experiences with others (Dewing, 2008). Strategies that promote learning in practice include creating continuous learning opportunities, promoting dialogue and enquiry, encouraging collaboration and team learning, and establishing systems to capture and share learning (Dymock & McCarthy, 2006).

The mental health team demonstrated examples of encouraging collaboration and team learning within the study. The most effective strategy for promoting practice change that emerged from the study was clinical supervision for the mental health team, where clear examples that resulted from clinical supervision were given. This supervision was undertaken on a one to one basis and as groups. The team also had regular team meetings where patient management and aspects of practice were discussed, and feedback provided. Likewise, if there was a serious incident such a patient suicide, an in-depth review was undertaken and feedback provided to all

concerned. This, too, was perceived in the study as a learning opportunity and brought about change.

The literature on clinical supervision suggests that it has value in supporting professional development, increasing clinical skills and knowledge (Butterworth & Faugier, 1992; NMC, 2006), but there is no empirical evidence that it improves practice and care (Brunero & Stein-Parbury, 2008). However, this study suggests that when embedded it is a valued integral part of practice, and that there could be a role for clinical supervision in practice change and development on both an individual and group basis.

9.1.3 Implications for higher education programmes of learning

One implication of the findings for higher education is the recognition that learning at work is a very effective form of learning and this needs capitalising upon. Siebert et al. (2009) suggest that learning at work is heavily influenced by social and cultural influences and this was supported by the findings of this study. They also suggest that learning takes place within different communities, of which learning as a group within the university has value, as has learning at work.

Fifty percent of pre-qualifying nursing and midwifery programmes are undertaken in the workplace where the majority of the learning is delegated to workplace mentors, who are qualified staff with a teaching and learning qualification. Academic staff with a professional background who work in higher education are required to undertake a clinical link role. It is the researcher's experience that this role focuses upon supporting mentors to promote learning in practice for students, but rarely do the staff directly promote learning themselves: they promote learning in the university and the mentors promote learning in practice.

Work based learning post-qualifying programmes are increasing in number and breadth, as evidenced through observations from the researcher's workplace. These programmes are usually a tripartite partnership between an educational institution, employer and learner (Siebert, et al., 2009). The basis of this learning through work is generally through the completion of a project, with the assessment

being a reflective account. It is the researcher's experience that this type of learning is resource heavy, in terms of teaching contact time for both the educational institution and the workplace, and does not fit into the standard framework for learning in the classroom.

The programmes of study that were valued by participants were those that included skills development alongside a mentor and encouraged practice and further development. Examples for the EIT included Masters in Psychosocial Interventions and Cognitive Behavioural Therapy. Continuous learning opportunities These types of programmes meet Dymock and McCarthy's (2006)recommendations that learning organisations create continuous learning opportunities which promote dialogue, enquiry and skills development. Learning is facilitated both in the community of practice in the workplace and the work based learning group within the university. The overall aim is to promote skill development and use teaching methods that promote critical thinking and the development of knowledge that can be abstracted from one context and resituated into another (practice) (Siebert, et al., 2009). These methods include action learning sets, experiential learning, and problem based learning.

9.1.4 Imposed change

The findings that emerged from the study were amalgamated and presented as a model of change and development, the Practice Change Model, see figure 10. This model highlights how participants respond on a daily basis to personal practice change and development within the context of their own workplaces.

This research has found that nurses make sense of change by incorporating it into their existing bricolage of practice, where it is made sense of in relation to other factors such as their own values, professional culture and issues in practice around them. New, imposed nursing practice was amended by the implementing nurse in order to make it fit into their existing practice. This amendment was not always good practice or cost effective: for example, the duplication of effort following the implementation of electronic record keeping, where the nurse made paper notes and then had to record them electronically at a later date. Effective strategies for

change need to have an inbuilt evaluation that will identify any unexpected outcomes.

This research also found that not all nurses respond in a similar manner to practice change and development, and this was highlighted by the model. The implication for practice is that when a change strategy is being devised, a 'one size fits all' approach may not be appropriate as traditionalists may respond to change differently from the innovators, contemporaries and progressives. The available literature on practice development encourages the implementation of initiatives to promote active learning, facilitation and enablement, using a bottom up and top down approach (McCormack, et al., 2009; McCormack, et al., 2004; McCormack & McCance, 2006), but the initiatives suggested do not seem to recognise that not all practitioners are at the same level of development.

9.1.5 National implications for practice change and development

Nursing is influenced at a national level by a range of organisations including central government, the Nursing and Midwifery Council, and the Department of Health. These organisations are concerned with the quality of nursing practice and influence nursing care through the setting of targets and standards of nursing practice and education. The Standards for Competence which are part of the Standards for Pre-registration Nursing Education (Nursing and Midwifery Council, 2010) highlight the competencies that are required of a newly qualified nurse. These competencies include communication skills. Those of the mental health field include a direct focus on developing self-awareness, which in the other fields – adult, learning disabilities and children's nursing – is less apparent. This study has found that practice change and development is heavily influenced by the self-awareness skills of the nurse such as the ability to recognise the impact of professional and personal issues. The implications for practice are the need to ensure that all pre-registration nurses are encouraged to develop their own self-awareness, and that these are an integral part of the standards required of a newly qualified nurse.

9.2 Limitations of the study

This study was undertaken on two samples of nurses from healthcare provider organisations, and the sample size was appropriate to the size of the study. However, the results could not be generalised to the wider profession of nursing. This would be resolved by repeating the study across a more representative cross section of nurses with a wider range of appropriate research methods used a with suitable larger sample.

9.3 Suggestions for further research

This study was undertaken on nursing but there are other professions, both health and non-health related, that undertake practice in the workplace. These professions include teachers, physiotherapists and occupational therapists. Further research could be undertaken to ascertain if these findings are transferrable to these other professions and the implications and impact on their practice change and development.

As has been highlighted previously, the research on practice development has areas of overlap with this study in terms of the outcomes, promoting participant involvement and active learning. There is limited available research on participant involvement within this area of study (Garbett, 2001; Shaw, et al., 2008). Some healthcare organisations have ongoing practice development strategies, and it might be useful to investigate the effectiveness of these strategies from the perspective of the healthcare worker who implements them.

Following on from the findings that relate to the Practice Change Model, it would be helpful to investigate further the most significant reasons for participants being at one end or the other of the continuum, and how they can be encouraged to move up it. Other areas for investigation include the extent to which personality, past experiences or the working environment influence this movement. Likewise, the impact of the workplace as a learning environment on nurses' response to change and their ability to move up the continuum would be a useful topic for further research.

It would be helpful to future practice change and development strategies to develop a self-assessment/attitudinal scale that identifies how prepared nurses are to be open to change in practice and where they fit on the continuum. This would involve employing quantitative research methods that could then be used to validate the model.

Although this study has recognised that intuition is an important feature of the process of practice change and development, it was not possible to elucidate this concept without further research. Further research could provide an in-depth analysis of the process and role of intuition in practice change and development.

9.4 Recommendations

1 National government and statutory bodies that influence nursing practice need to recognise the importance of developing self-awareness and learning through work within their targets and standards.

2 In order to recognise and promote the effectiveness of the continuous nature of practice change and development, organisations need to consider implementing strategies that include top down and bottom up approaches, take account of differing responses to change, and are embedded throughout the organisation. These strategies would need to reflect commitment from all levels of the organisation, be resourced appropriately, mapped across appropriate strategies and preferably involve partnerships with Higher Education. Enabling and supportive frameworks embedded at practice level practice development posts or champions in practice may be useful examples for implementing change. An integral part of the strategy would be the promotion of active or work based learning. Consideration would need to be taken of the individuals' differing approaches to change, and supportive mechanisms reflected within the initiatives identified.

3 With the emergence of learning at work as a significant part of practice change and development, Faculties of Health within universities need to consider further embedding work based learning frameworks into their mainstream

programme delivery. This could be across both pre and post-qualifying programmes, and would support healthcare providers in their strategies for change.

4 Faculties of Health within universities generally devolve learning in practice for pre-registration programmes to the mentors that work in practice. This study recommends that learning in the workplace becomes an integral part of the clinical link role, and that the boundaries between learning in the workplace and in the classroom are blurred. The whole strategy of the role of the academic in the university versus their role in promoting learning in practice needs reviewing, with a view to valuing the latter as much as the former. Learning in practice needs to be an integral part of the role of the academic in their clinical links role, and include more practice based learning opportunities, not necessarily working in a hands on situation but utilising strategies such as case presentations or group supervision sessions to which qualified staff could be invited. Some modules could also be taught in the practice setting.

5 Strategies employed for imposing new practice changes need to take into account that any change in practice is more likely to be effective if those who have to implement the change understand it and are motivated to succeed. This means that the change needs to be appropriate to the nursing care for which the change is applied. The change strategy would then need to address the concerns and realities of that change, and include assessment and amendment of the structures in place to support the change, appropriate education or training with follow up support in practice, and a full evaluation of the impact of the resultant change on all stakeholders, including patients (Stevenson, Dahl, Berry, Beck, & Griffie, 2006).

It would be sensible to integrate all changes of practice into the one strategy that was identified in the second recommendation. This could include the identification of a change agent or champion, preferably one who will be using the new practice, with an objective of implementing strategies that facilitate sense making, allowing practice debate and sharing, developing shared frames of reference, and ensuring

ownership of the change. The change agent would need to be an advocate for the changes being implemented, emotionally committed and also willing to take ownership of the changes being sought.

Appendix 1: Compilation of a range of transition models

Author	Date	Research base?	Stages of transition	Categorisation
Lewin	1951	Research into housewives' behaviour	Unfreezing, moving, refreezing	Based upon behavioural changes and includes the concepts of driving and restraining forces.
Havelock	1973	Based on literature review from changes implemented in teachers in schools	Awareness of the innovation, growing interest and active information seeking, evaluation of the innovation, trial and if successful, adoption, natural diffusion once 25% of the population has passed the five stages	Social interaction model that is based on the stages of decision making that the individual goes through as the change is adopted.
Rogers	1983	Research into how farmers adopted innovations along with a literature review of existing studies	Innovators, early adopters, early majority, late majority, laggards, rejecters	An expansion of Lewin's work in regard to driving and restraining forces.
Pelman and Takacs	1991	Observations of organisations whilst undergoing a period of organisational change	Equilibrium, denial, anger, bargaining, chaos, depression, resignation, openness, readiness, re-emergence	Based on emotional grief and builds on Kubler-Ross's study of grief-work (1965). Each phase is characterised by varying energy levels, attitudes and willingness to engage in change strategies.

Author	Date	Research base?	Stages of transition	Categorisation
French and Delahaye	1996	Based on a literature review	Security, anxiety, discovery, integration	New model derived from a literature review that is continuous and cyclical as opposed to linear and insular.
Strebel	1998	Research on organisations	Change response individual types: Traditionalists, bystanders, resistors, change agents	Based on an approach to implementing new initiatives and dependent on the relationship or 'compact' between the individual and the organisation.
Broome	1998	Research on organisations	Shock and detachment, defensive retreat and confusion, acknowledgement and adaption	Linear model identifying psychological responses
Knight, S	1998	Grounded theory study, mapped the stages of transition over a two year period during the implantation of a new nursing curriculum	Lack of group identity within the change context, disequilibrium loss of control, Adaptation: waiters, movers	Identified similarities with the grief response and Lewin's models.
Salmond	1998	Based on a literature review and experience of managing change in the workplace	Know the type of change, separate the change from the transition, anticipate the multiple losses involved in the change, deal with the emotional responses to the loss, put an end to the past and move to the future	

Author	Date	Research base?	Stages of transition	Categorisation
Bridges	2002	Working with and observing organisations in managing change	Endings, neutral zones, new beginnings	Gap connection approach takes into account individuals involved in the change and the degree of movement involved between the old and new situation (French & Delahaye, 1996b)
Carnall	2003	Research into organisations	Five Stage Coping Cycle: Denial, defence, discarding, integration, adaption	Behavioural approach that links response to change and impact on self esteem
Kotter	2007	Working with and observing organisations in managing change	Establishing a sense of urgency, forming a powerful guiding coalition, creating a vision, communicating the vision, empowering others to act in the vision, planning for and creating short-term wins, consolidating improvements and producing still more change, institutionalising new approaches	

Appendix 2: Information sheet for participants

INFORMATION SHEET FOR PARTICIPANTS

Linda Meredith

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PRACTICE CHANGE AND DEVELOPMENT: THE INSIDER VIEW

I would like to invite you be interviewed as part of the research study that I am undertaking. Before you decide if you would like to be included, it is important that you understand the background and the aims of the study. If you would like more information, I would be very pleased to discuss it further with you. My contact details are above and I am available 09.00-17.00hrs Monday to Friday.

Aims of the study

This study is being undertaken as the main study as part of a PhD and it is anticipated that it will take eighteen months to complete. The aim is to explore nurse's responses to change/development in their nursing practice. This will involve for example exploring what change and changing practice means to you. It will involve identifying incidents when you consciously changed or developed your practice and reflecting upon those events. It will also explore incidents when you consciously decided not to change your practice.

Why have I been asked to take part?

You have been invited to be part of the study because you have been identified as a member of an early intervention team in the Cheshire and Wirral Partnership healthcare provider organisation. Participation is voluntary and you are able to drop out at any time without any explanation.

Should you wish to be involved you will have this information sheet to keep and be asked to complete a consent form.

What will I have to do?

You will be interviewed for about 40-45 minutes and the information that you provide will be taped, transcribed, analysed and used as part of the PhD submission.

What happens when the research stops?

If for some reason the research is delayed or stops, you will be informed as soon as possible.

Confidentiality

I will ensure that all information gathered as part of the interview will be kept confidential. Your name and identity will not be divulged to any other person and you will not be identifiable anywhere in the documents produced as part of this research.

Sponsors and reviewers

The research is registered with the University of Liverpool and being sponsored by the Faculty of Health and Social Care, University of Chester.

Thank you very much for taking the time to read this information sheet and I hope you will be willing to take part.

Linda Meredith

Appendix 3: Consent form

CONSENT FORM

PRACTICE CHANGE AND DEVELOPMENT: THE INSIDER VIEW

Researcher: Linda Meredith

MAY 2008

1. I confirm that I have read and understood the information sheet dated MAY 2008.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reasons.

3. I agree to take part in the study.

Name of nurse participant Date Signature

Researcher Date Signature

Appendix 4: An example of a transcript of one interview for participant B4a

Researcher

Could you tell me what your role is please?

B4a

My role is um I'm a nurse working within the team partly as team manager, partly as clinical lead, I supervise everybody in the team, I carry a case load so I assess people, fill out care plans and quite often deal with the more crisis type clients and support people with the concerns that they have, usually at the rougher end of the spectrum rather than the more pleasant end.

Researcher

So what did you do before this?

B4a

Before this job, I've lived, always lived in London all my adult life even though I am from Liverpool, so I worked since I qualified as a nurse in 92, I worked in drug and alcohol primarily detox units, community drugs team, um method and maintenance clinic and then I moved into working with homeless mentally ill on the streets of London, for eight years. Then I went into managing a team for two of those years, that was four years ago and then I came to this team in gosh, I moved up north in October 2004 to set up the service and I have been here ever since.

Researcher

How different is this role to what you were doing before?

B4a

Um

Researcher

I suppose I am looking for what skills, or what did, how did you have to develop to take on this role?

B4a

OK well, I had never done project management before, so I had to develop a whole service from scratch. So I had to learn a lot on my feet really. Um I guess I was a lot more politically involved in this role for example. Being involved in a lot more in sort of developing links with local services um CAMS, working across interfaces of younger people, adult um not upsetting too many people, people who were upset about the whole notion of early intervention at first because it stepped on other peoples toes. It took some of their clients away, the so called sexier end of the spectrum, of working with an adult disorder. Um they didn't think we were specialised at doing it so I had to become quite political and quite were as usually I am used to engage with patients and families which I still have to do now. I became a lot more aware that I had to engage with so called colleagues within services; um yes that was a big difference

Researcher

How did, what, how did that develop? How did you go about it?

B4a

Um how did that develop urr **?**

Researcher

How did it improve? How did you gain skills?

B4a

Um I suppose I already had a lot of the skills, I was already a team manager when I came up here so I'd already been, it just became a lot more intense, not knowing people and not being known made it more difficult for me being in this area cos I was just some guy from Liverpool who'd come from London, so I didn't know anybody. So it's quite an isolating job when you don't know anybody and your one

person representing a new service. Um so I suppose I did a lot of it independently, I was quite isolated at times, quite unhappy in all honesty when I started. Um obviously it's a lot of reflective, sort of reflection in my own time, weekends, sleeping became a bit bothered. That sort of preoccupation, but that's my own style is that. I kind of criticise myself and eventually find out, no I didn't really do anything wrong there, that was part of the process of engaging other people and getting other people to trust me, and um getting other people to realise- actually can do this job and I know what I am talking about. Um

Researcher

You said you go through a period of reflection, was there an actual process there?

B4a

UM I think naturally, I did my SPQ, specialist practitioner qualification in 1999/2000 and that helped me realise I was quite a reflective person anyway, I've always used supervision in god fifteen years now, I've always been supervised brilliantly, I've always been really lucky so that's my way of reflective practice. Sometimes comes from supervision because I will talk, talk, talk. And in so doing realise, gosh I'm under a lot of pressure here. And then afterwards sometimes think back um about where I can improve, sometimes I say too much, sometimes I can say the wrong thing, its passionately driven yet, it might come across in the wrong way.

Researcher

Apart from that supervision do you use any reflective model, any specific model?

B4a

I wouldn't be able to, I guess I couldn't cite exact models, I mean I could tell you I've been on supervision courses and um I've had lots of different structured processes for the interview, different subjects, clinical, reflective, managerial whatever it is. No particular model I can think of.

Researcher

Can you describe a client that had a huge impact on your practice?

B4a

Currently or previously?

Researcher

Whatever you would like to talk about?

B4a

Gosh

Researcher

One that sticks in your mind

B4a

Ok um I can easily think of one that was a quite negative experience, definitely yes, shall I tell you a bit about it?

Researcher

Yes please

B4a

It was when I first started working in- Id been travelling, came back in 1996, I'd been away for a year and I didn't want to be a normal nurse, I didn't want to go back into psychiatry, I've always been doing something I guess a little bit different, so I went to work within the homeless field. And it was a bit hippy I suppose, it felt a bit, maybe following on from my travelling, went into my job, went out to my job, went out to assess a young lad, realised how ur, how I lacked some skills in terms of assessing mental states and I was learning, I was young. I was twenty five or twenty six and I really had, on reflection I think a year or so later, I looked back at this young lad, he had a Spanish name and I can't remember much about him but I thought I really let him down. Um not , not that I beat myself up about it, but I

thought goodness me, you know this kid, if he'd have met me now for example, and I may be thought back a year or so later, wow I would have done it differently. How would I, I would have done a mental health act assessment, I would have got him in hospital, not that I'm pro psychiatry particularly but I know when somebody needs to be detained, and I know when someone needs to be treated and then I know you get them better accommodation and they get on with their life. He was really unwell this poor kid, um that made me probably realise that I, I suppose it made me realise that I had learnt a lot, but also the importance of um disclosing weaknesses and being honest about , not being sure what I am doing with this patient, and now it really influences me when I say to people, I just had supervision before you came with somebody and I said to the man I need you to be clear with me about these patients that you are working with, why you are seeing them, what you are doing, and then also what you struggle with? And it may be that you don't know why you are seeing them and what you are doing, and that's fine but you need to tell me. And I guess just talking to you now, yes I haven't thought about this lad for probably five or six years. But he was a good lad. There is also my brother. He is the most influential person in my career; he's also got a mental health problem. He's got Aspergers and he's probably the biggest driving force in terms of what I learnt, when he goes into hospital and the shocking treatment he gets.

Researcher

Is that ongoing now?

B4a

Yeh, yeh yeh. It's been going on since I qualified as nurse, well a few years after that. He's been all over the country, been away travelling and he's tried to kill himself, pretty amazing, pretty horrible stuff but amazing for me in terms of my practice, it really helps, um there's obviously not nice things to it but

Researcher

How does that personal experience help your practice?

B4a

Totally, yes I see it from a totally personal point of view and it makes me feel more passionate than I otherwise would. But it makes me, makes me sometimes see beyond the rigidity of services and people just looking after them. That's easier said than done when you are running around and sometimes like the proverbial.

Researcher

Is a lot of that experience? And what you do with that experience?

B4a

Well yeh I suppose things are clearly, I can cite two examples of somebody I've worked with and learnt from, my brother, um I also- yeh definitely, yes

Researcher

When you have the experience, is it the reflection afterwards and what is the process? I'm trying to think of an example, I mean the Spanish guy, and how long after did that experience impact on your practice? A year as you said?

B4a

No I don't think so, I think I was thinking at the time, on reflection, I felt uncomfortable at the time, and I think you become more aware the more experience you get and how often you sometimes feel uncomfortable and how much you get because of dealing with the complexity of emotion and humanity and then you throw into that already complex bag, you throw in psychosis and mental illness and abuse and all the rest of it and it just becomes understandably totally insane and totally, almost impossible to deal with and what becomes amazing is when you are able to be objective in those situations so I think, you know you feel uncomfortable, and at the time, being a young lad, probably feeling quite, well very confident, a bit stubborn and a little bit embarrassed at the thought of admitting that I had been feeling bad ten times in the last week and I don't want to do it. Although to be fair to myself I did know what I was doing, I knew I was really trying

to care for this young lad and um he was taking lots of drugs. So its part of the process of the nurse developing and learning, reflecting and moving on and changing and that is the important thing. Even if I had never been consciously aware of how reflection and learning lessons makes me change, but of course it must do and it does do because just thinking about it, managers supervision, somebody will say- why do you do that? Sometimes I can say I know why and sometimes I say I've no idea.

Researcher

So supervision is about exploring experiences

B4a

Yes but I've had lots of different supervisions and so I've, I don't get supervision to be honest any more. I just, I get managerial supervision, no one really, for two years since I moved up here, two and a half years um its funny talking to you now because I don't, I just don't get it. I just, people know that I'm competent, I'm sure they know that, and I'm confident, they know that cos I am, I hope I feel very comfortable but, its what I miss more than anything, it's what, I want eventually to go into say therapy and all that, that's what I want to do next. I miss it so much. Managing peoples great but, um . So no supervision and the different styles I've had of supervision, I really psychodynamic type supervision where somebody is just reflect everything back to me, I don't mind that cos as you can tell I don't mind talking. But um it's allowed me sometimes to, erh, feel like that. When I reflect back on a supervision sessions sometimes I go in feeling really busy and often I come out thinking, this is much more manageable because you're allowed, being allowed to take everything out of your brain, throw it onto the table and put it back in an organised way. And that just settles you down, you know, I compare it to my poor wife whose, my poor wife- it sounds rubbish, my poor wife in terms of, she's never had supervision, she's been qualified exactly the same amount of time as me. She's a general nurse but she's a wonderful nurse, I've absolutely no doubt, but she's never been, when I talk to her about supervision she always says, it's so nice of you to do that, you're so lucky, we get it but over a coffee and it's with several other

people there and the phones ringing. And it's not really even any way near supervision, it's miles away.

Researcher

That's what I wanted, thank you. Are you involved in any change at the moment? Is anything changing in your life?

B4A

Outside of work, anywhere?

Researcher

Inside work would be helpful.

Any change imposed on you or any particular areas in your mind you're developing?

B4A

Within work the main thing that's changing is the service is developing and growing, whereas initially you had half a million pounds to spend on the service and recruit accordingly, we've just been given another half million to really grow the service, so over the next eighteen months it's going to grow from twelve staff to thirty. I'm just involved in recruitment, um I've got a short list for staff, so it feels like an enormous pressure and right now cos I've got outside of work I've got kids, two children, four and five and two, um I've got people going off work life balance which I want to give. And I want to work life balance myself to take time off in the summer holidays to look after my children but, I'm having to not be able to do that because I can't, I won't have the time. So it's, what's going with me right now is, I'm feeling really squeezed. I feel really squeezed, by my job, definitely. I'm meant to be on holiday next week and it looks like I'm going to have to cut my holiday short, which is just, I'm quite a strict person when it comes to my own time. In fact I'm probably saying this to you now; I think I'm going to bloody well prevent it. I have to be with my wife. Um so I'm really, the thing with me is trying to balance; I'm trying to keep all the bits OK, keeping everyone happy, dealing with all the risk issues. You know I

was here until six last night with a patient. Hearing the patient had tried to strangle his wife and you know those sorts of things you can't say no to, but then you've got to pick up your child from nursery, and be out of there. You just get on with it. I don't, I do enjoy it.

Researcher

So the biggest thing is handling the service and managerial aspects, interviewing?

B4a

Yeh

Researcher

Supporting people?

B4a

Yeh, yeh, and just keeping all of that, and keeping my head above water and keeping reasonably sane, I guess and keeping calm

Researcher

Keeping calm?

B4a

It is important, I'm quite a hyper person, but at the same time I also know that when I am with you now I get enthusiastic, which is great, but when somebody comes in and tells me that their patients are strangling their wife, then I am very different. So I can be, the important thing for me is to have, to have erh, I think of it like in a psycho synthesis kind of , all of the different needs come in to play. And I'm quite good at playing a role, so that's something that something I have to keep .....keeping control really.

Researcher

At this moment in time within your role what are the challenges?

B4a

Yeh getting the right staff in is a challenge I kind of look forward to. So it doesn't feel daunting at all. Um keeping people happy to be honest again, it's just the amount of stuff, none of it feels daunting, it just feels; I told people the other day and I don't like having to admit this, but I said to people, I'd rather be honest and I don't, I'm not normally a drama queen in terms of, I don't really care if I cant deal with stuff, said to people the other day- I am honestly so busy that I really cant give you the time I would want to, in terms of being in the office, listening, and responding. I go to that office and people, I just get, 'you got a second'? when you got a second, when you got a second?' there might be four people in there. You know or there might be eight people in there. But in here, I had supervision this morning and I was interrupted three times in forty five minutes. So the challenge for me is time management probably, and prioritising and being calm

Researcher

Calm?

B4a

And as long as I keep those things, because I know sometimes, cos I like to listen to my staff, when they say I'm really stressed out about something I like to be positive and I like to listen to them and that's a challenge because you have to listen to people, you have to show them that you know that their concerns are valid, but you also have to be positive and have an outlook that says' we can do this, it will be fine, don't worry, I'm confident that we'll do it. So you take on responsibility then.

Researcher

What help do you have to get through this? Help you prioritise?

B4A

Erh no, I have supervision, and he is a really nice manager as well. I just think we have so many things going on at the moment, um and I think as well the

management supervision that I've had since I've been in this trust, this is all confidential isn't it?

Researcher

Yes oh yes

B4A

So the supervision that I've had in this trust is definitely been, I must be honest, it's been poorer quality than I am used to. And I think it's because I'm going up the ladder, I'm not even more senior than I was, I've been equivalent like to the grade I am now for four years. It's awful. I guess the difference is that I am actually involved in developing the team, which is very different from all my other colleagues in adult mental health. That's got .. the other challenge is I've moved offices in two years, three times and I will be moving again within six months. People don't quite appreciate that, how unsettling and how hard that is. Um so no I don't get. I don't suppose often that I try to bring it to supervision, I try to bring the, the enormity of the stuff I'm doing, but sometimes the question that I'm asked, the inquisitiveness of the person who is supervising me, which directs me. And you're making, you're asking me things that encourage discourse and reflection and erh you know, and it's the way it works here, we have a service manager who manages four of me, five of me and I pretty much do ninety, nine point nine, nine percent of the job. But they get paid as a service manager to manage my service. But they're involved in lots of other things out there, meetings, deaths, complaints. Meetings, meetings, meetings about new change and so meeting me is, so on the one hand I want to portray that things are going well, cos they are, but that's fine. I get questions like' how can I help? What's going on for you at the moment? Or maybe I need to take more responsibility and utilise that more. You know but its, there's so many other things that come up like. Ok how are we going to spend the half million pounds? And I have to, I've got a plan here, I've written it all out, here you go, there's how I see it over the three year plan. Recruitment, meeting targets for caseloads, um dealing with staff that are under performing. Um where are we going to move to when we have five more people starting in two months' time?

When do I get that piece of the answer, I don't get chance to think about me? That's the honest truth and that's not being a martyr, it's just that's what I do a lot, don't get a chance to think about my own needs. And I think I know as well cos I am regarded by, I think I am regarded by lots of people as good at my job. Um some people think I am a bit of a soft touch. I know that some other managers think whenever I propose an issue to them, sometimes my own line manager now, for example a young lad, a member of our team who is off with some optical neuropathy, he has some problem with balance and dizziness. He might not be able to drive for twelve months. My line manager said he needs to be reallocated somewhere else. He thought we might be able to accommodate him within the service in a different way. He says do you want to? I said well what about him? He's a good nurse, um but he's a caring guy, it's a more, I guess I'm a bit more soft is that's the right word, I would say a bit more compassionate. Um and he's always said to me ooh no I'm much more black and white, I'd have him down the performance road, and it's like if I do that then it makes me ostracised from my team and I'm not very good at dealing with being ostracised from my team. So we are a bit different.

Researcher

So it's how you see yourself and your role?

B4a

Yeh, Yeh sure

Researcher

Could you describe any routines that you follow in your work?

B4a

Are you asking me if I have got any obsessive compulsive disorder? Laugh

Um yes and yes, um do I follow any routines? Do I follow any routines? Such as

Do my clinical notes and then go into the office?

Researcher

When you come to your patients could you describe any set routines that have developed?

B4a

Oh no, I don't think so; I think I really think on my feet. But then having said that I might be totally in denial there might be very fixed routines. Um

Researcher

I am not saying that there is anything wrong with them, I'm just interested to know what part they play in your professional life.

B4A

What routines?

Researcher

Yes routines

B4A

Um I suppose in terms of clinical stuff with patients, seeing patients. I'm quite informal, um

Researcher

Do you follow a protocol, perhaps routine is the wrong word, do you follow a set series of steps for instance when you are assessing clients?

B4A

When I meet people for the first time I guess loosely I do, when I meet people for the first time yes, I guess, I yeh, I guess I do. I think there's a degree of formality when I first meet people, and I would explain you know, often I would say- first I

would introduce myself, would it be useful for me to just to describe why I think I am here today? See what you think. Um tell them what the teams about in a broad sense, um or I might say would it be more useful for you just to tell me what you, why you think we're here and give them the opportunity to control the first few minutes. Which is obviously preferable because then I can say OK and now I know where we're at. Um so yeh I do have a routine but the moment you go into the sort of sessions that I go into with people, initially with new people, it's the first few minutes that dictate everything because what they say, how they are, how they look, the information I received from the referral, which may be totally inconsistent with the presentation I'm getting. Um often we will see a person with two of us, who again changes the dynamics immediately in introducing each other, one of us takes the lead. It's quite intimidating if it's a young person who's paranoid. Its, you've got to feel a lot, you can't just, and by that I mean you've got to look, listen, read, pre-empt, plan it before you go into the session- who is going to speak first? who are we going to introduce? Tell them about confidentiality, but do it so that you don't scare them. So I am very aware and I guess and my initial answer was no,no,no, but of course it becomes second nature. You're intention is to assess, get a clear picture but also to make the other person feel comfortable. So you can't come across as if you are formal, formal, formal. I've got these things that I want to ask you like often a doctor might have to because they've got five minutes in a GP surgery, you know wouldn't involve looking at you, wouldn't involve saying hello. You know its worlds apart from the nursing approach.

Researcher

So generally no you wouldn't?

B4a

Generally have a routine?

B4a

It depends how you define a routine, I would say that loosely there is a routine involved, but not a scripted every session will be the same, definitely not because

they're all, people are too different to have, I think people are too different for us to have set routines with the client group that I work with. Having said that, previously when I have worked with people with substance misuse, it might be more of a straight forward thing. You're here because you take too many drugs. It's pretty clear, you are referred to us because you are drinking ten pints of lager seven days a week, is that right? Yes. Right well let's talk about it. This is more difficult, this is more different, more complex.

Researcher

OK, can we change track a bit and go back to your own personal values? I mean you talked a bit about your brother, how do your own personal values impact on your practice?

B4a

I would hope and I would imagine enormously, but how, how is the question, rather than do they?

Researcher

Can you think of what values you bring to your practice?

B4a

Ok- values, whew god where do you start with values? A value about 'caring for other people'. Um value of life, in terms of keeping people alive, giving them the best opportunity to fulfil their potential, um making moral values, in terms of what's right and wrong and being pressured in life to look after yourself , i.e. don't put myself under too much stress, is the importance of giving to other people and something which loosely influences me which isn't religious, well it is religious, but not religious in the common sense, it's more um, I'm a more philosophical person like Buddhism influences me enormously, so doing things for other people without exaltation that you necessarily, you do it because you know it's the right thing to do. There's a value, that's a value driven behaviour; Um other values- maybe fairness, with people who I have many reasons not to be fair towards. Objectivity is

another value that influences my practice. I've had people who have really upset me and I'm sure there is times that I have really upset them but, It's been unintentional and I've apologised, that's quite unusual, but people, but even when people have been openly slating them, and been condescendingly quite derogatory about them, I will try and defend them. And I hear myself doing it and think, goodness me why are you even bothering? Well it's a value of fairness and being objective and I'm a manager for these people and if I don't defend them who will? They let themselves down enough already, so why should I try and get the boot in. There's no being angry with them, that's more about the Buddhist sort of stuff that I'm interested in, it's like being angry with them when they are angry with me, I should still show compassion and be caring and believe that they will come round to being good people, then they might not, but what is the point of responding. So my use of compassion, fairness, acceptance, something about accepting what I can, you know the old serenity prayer. My mum was a big sponsor of AA and stuff, so we talked about that a lot. Um but there is a massive amount available out there between philosophy and accepting what you can and can't change.

Researcher

Do you; is much of your care driven by evidence? Evidence based practice

B4A

More so, more so when I was doing my SPQ , my degree thing, about seven or eight years ago I became quite suspicious of quantitative based evidence and the CBT driven agenda now and still am very suspicious of it. I understand it's a juggernaut that no one can control and the Department of Health and various other- I was down at the Maudsley and the Institute of Psychiatry, I was closely linked with a Professor who was higher up in the, I wasn't linked remotely to him, but I was closely there and I was part of lots of stuff that was going on. My clients in mental health services were homeless, and were taken out as a possible pool of research because they were far too complex. I.e. they were far too real. So in my, evidence based, when you look at other stuff, more qualitative and quantitative stuff, we're looking at family interventions at the moment which has an enormous

evidence base. We, in terms of the psycho-medication we use, in terms of the education of families and young people, it's very difficult to quantify such evidence, but it seems to be broadly agreed internationally. Within the early intervention movement it's really powerful and important stuff. Involving families and carers loosely, its not strictly family interventions but loosely its assumed because the family intervention evidence base that um it has value in reducing admissions and improving outcomes so, I would say much more so now, because early intervention is fairly well evidenced. Previously I've always been a bit paranoid about evidence, bit suspicious of the agenda, um not quantitative stuff, the qualitative evidence you know, obviously some nursing qualitative stuff certainly in mental health looks at is caring for people enough, is the sort of, of course some people try to show that alone isn't anything to do with it, but I think utter nonsense. There's got to be some truth in if the person is a rounded, reasonably rounded caring objective person, then there probably make a difference compared to somebody who needs some care. That's me getting paranoid again about evidence base.

Researcher

So I suppose you've told me about the conflict between your own values and the evidence base for the care that can't be covered by the evidence base because the evidence base isn't there really.

B4a

Yes I think it comes, a lot of it, when it comes down to my own clinical practice and within teams, bearing in mind the team that I manage, I do manage a consultant psychiatrist, which sounds bizarre as he earns three times more than me in salary. I manage a consultant psychologist, um and I manage the whole team, all the different disciplines. I guess what it comes down to often is, if I had someone else who really evidenced based, really medicalised, I'd have more logical arguments and discussions, but what seems to be the order of the day, or wins the day in my team is common sense. And so it comes back to well, people don't often say, sometimes they do, give me the evidence based argument and sometimes it's a very, very good point. And if it helps me reflect and think actually there's some

truth in, we need to be more consistent with policy implementation, what we should be providing, but um, I guess it does conflict sometimes, it's just the sort of, just the rigidity of it. And humanity isn't rigid, humanity is so much more fluid and flexible and we have to be, we have to take on benefits of both I guess, its back to that old thing in the end, how many times do we all do that? Laugh, so it's about taking what you can from something and knowing that, I can't get back to the serenity prayer again, god I'm not even alcoholic, but maybe I will be if I carry on in this job much longer. You know going back to CBT has its benefits but it has its limitations as well.

Researcher

Thank you for the interview, just one more thing to finish; could you tell me what you are proud of?

B4a

I just think, and it's always the way whether it's here or in the I think the people that I work with I've got a really good relationship with them, it's a good balance of being professional but also being friendly and warm and just kind of getting on with people. So I think is probably the thing that I am proud of, the way that I engage with people and just you know people that are quite difficult to engage with sometimes. That's probably it.

Appendix 5: Vignette and interview schedule; part B of the second study

Scenario 1

The healthcare provider organisation has employed a well known management consultancy firm to improve the service that it provides to clients. Following an extensive audit into healthcare practices across the healthcare provider organisation, it has decided to implement a new patient assessment process for use with all clients. This assessment will replace all existing patient assessment tools and will be implemented once staff have received training.

Scenario 2

The healthcare provider organisation has decided that once the new assessment process is embedded, assessment data will be collected by a research team and used to identify a series of benchmark statements for all teams. This will involve staff submitting assessment data electronically on a weekly basis and being interviewed twice about the service they provide.

Scenario 3

The management consultant has designed a staff performance review policy that will be linked to the benchmark statements that have now been identified. This will replace all existing appraisal and staff development interviews that have been used previously. The plan is to eventually link staff performance to training and salary. Your department is to pilot the process, starting next month.

Interview schedule following the vignette

What are your immediate reactions to this scenario?

What would be your response if this happened in your workplace?

What would be the challenges for you?

How would you overcome them?

Could you describe to me one significant change in your professional life that was imposed on you?

How did it affect you?

How did you feel about the process?

What were the challenges for you?

How did you deal with the effects of the change?

What was the outcome in the end?

Could you describe to me one significant change in your professional life that you initiated?

How did it affect you?

What were the challenges for you?

How did you deal with the effects of the change?

What was the outcome in the end?

How would you describe your responses to change?

Appendix 6: Example of line by line coding within the transcript for participant A2

Transcript of the interview	Line by line coding
A2 Again, from other staff, you know both either from professional people or to a particular source within that speciality. It is again dealing with new staff, tissue viability, and infection control for instance. Even our own consultants GPs, doctors, they all, I feel for me in my development, are a real strong wealth of ideas, information, and research even.	Valuing, seeking and accepting colleagues' knowledge and experience. Looking inwards for answers
LM If you take for instance a tissue viability nurse, can you give me an example of one who influenced your practice, can you think of an incident?	
A2 Yes it was roughly about 10 years ago and it wasn't MRSA. Again it was a very difficult pressure sore, if I remember rightly and we had had to ask for his help as the products or whatever we were doing, and the sore was quite severe, it wasn't improving. He came along and quite efficiently and quickly once we had referred and again he could sort of identify and explain what was going on with the wound and suggest a product that would help us to start coping with this.	Feeling that care not effective. Needing help Looking to others for their experience Filling in background knowledge, offering expertise.
LM Did it work?	
A2 Yes, well I felt that it did. You know that's what struck me was that there was far more to it, not just for what you	Not knowing what they don't know

actually see, but what you actually have to think about. **LM** So he gave you different ways of looking at it? A2 Yes and again reiterated I suppose the physiology of what had happened to the deep underlying problem that the patient had. You know the stages that a pressure sore went through. I mean we learn all of that through nurse training, and if you are fortunate enough through your training to see a severe pressure sore, that's all very well but again if you do, you may only be dealing with qualified staff who aren't quite sure on how to deal with it. So effectively I felt that the likes of the specialist nurse was more effective to the point without us having to be wandering in a quandary .It was more efficient, it seemed to be the answer rather than fishing around the floor for ideas.	Looking backwards to past experiences for answers. Looking to colleagues who may not have the experience Valuing specialist knowledge Justifying why can't know how to deal with all situations

Appendix 7: Memo 10 – An example of a memo used to develop categories

MEMO 10

15th July 2007

Am at the end of the first part of the study and need to be aware of categories to date and areas for development. These are the categories that are emerging at the end of study A:

How practice changes

This category defines the nature of how nursing practice changes and develops over a period of time. Participants identified that there were several levels of practice development. The first is the hands on personal change that happens on a daily basis. The change is personal to the participants, not influenced by the requirements of the clinical area that they work in or the organisation. Examples include communication skills, participant 2, 7, developing skills to take on a new role, participant 3, making beds, participant 5, and assessment skills, participant 7. The participants have control of this aspect of practice development.

Secondly there is practice that is carried out at ward or clinical area level and examples of this are aseptic technique, wound dressings, the use of talcum powder in dermatology.

Lastly the healthcare provider organisation identifies some nursing practices that are required to be carried out to a set standard organisation wide. There is an element of control exerted by the organisation to quality assure these practices through adhering to recognised benchmarks, national guidelines such as those set by the National Institute for Clinical Excellence (NICE) published evidence and requiring nurses to follow guidelines and protocols. Examples include the use of red trays for patients who need adapted cutlery, pain assessment scales and computerised patient records.

Those participants (2, 4, 6) who had a managerial role talked extensively about the clinical area and healthcare provider organisation wide aspects of nursing practice

and identified nursing practices that they changed or influenced. They were also able to discuss their own personal practice change to varying extents. Participants 1, 3, 5 and 7 took on a much more hands on approach within their role and were more easily able to discuss aspects of personal practice change than the managers.

Personal process of practice change and development:

The title of this category came from participant 1 who talked about the 'personal process of practice change and development'. This is the process that the participants undergo as they change or develop their practice. The focus of the change arises from the day to day experiences, and to what extent they appear critical with regards to their practice. The impact of negative and positive experiences on practice change, whether reflection takes place and if there is a recognised process, all fall into this category.

From the data it would appear that the process of practice change and development centres around the experiences that the participants have on a day to day basis. Participant 6 was the only one who did not refer to experience as being the main driver for changing nursing practice. This experience is used to increase knowledge that is applied to practice (participants 1, 2, 3, 4 and 7) and having repeated experiences leads to a more effective way of undertaking practice with a greater ability to forecast (participant 1), more awareness of what you are doing (participant 2) and being able to undertake care more quickly (participants 1, 2 and 3).

Being in a continual learning situation was identified by participants 2, 3, 4 and 7. Participant 2 was the only one who identified how learning relates to the development of practice, as highlighted below:

> 'You didn't learn really why, the underpinning thing with that. Whereas as I have gone on, I identify gosh that's why you do that, things slot in better. It's like learning to drive, you go through the motions. It's only later on that you can actually alter it and actually do it right.'

The other participants referred to being on a 'learning curve' or 'continually learning'.

A process of appraising available information in order to identify care was cited as part of the process of practice change and development. The process involves referring to previous experiences, balancing the decision against available evidence or knowledge base, common sense and what the patient will accept. The evidence can come from research, national benchmarks, protocols or guidelines or published evidence. There was a dimension to this process with some participants using all the stages and some only using parts. Participants 1 and 3 only used experience and referred to other professionals for the evidence base when identifying care.

Participant 5 identified the need to balance knowing from experience and prioritise care particularly in relation to the use of protocols to prescribe care:

> 'If you've got a really poorly patient and they need the one to one care and the same with the relatives as well. Cos if you check the catheter and it's been in for x amount of time and it's due to be changed, or changed over to a long term or whatever, then you've got a poorly patient who's been given bad news, you need to support the patient and you need to support the relatives. If there is no sign of infection or anything wrong with the catheter, I feel that it is the time that the patients or relatives need and I will go back to sort that out the next day or maybe pass it onto the next member of staff.'

Participant 2 however, identified the whole process when changing practice. This example highlights how the evidence base is balanced with what has been learnt through experience:

> 'Let me give you an example, potassium permanganate, it has been shown that with repeated use it is carcinogenic. It is one of the best things that you can use for an exudating wound. We are probably a bit more mindful of using potassium permanganate; we don't use it any longer than necessary. We don't steep them in big baths and leave them for an hour, like we used

to do. We get blistering conditions where we put people in potassium permanganate baths. We used to bung in a couple of tablets, but now we measure the amounts so that the dilution is correct. Whereas before we might not have and they would turn out deep purple, now we do it rose pink. So it is modified.'

The following example from participant 2 highlights how experience and evidence is balanced with patient compliance:

'It's like with compression (bandages) you're supposed to put a certain amount of tension on it and some people don't like a lot of tension, you have to modify it for compliance. Some people can take it, some can't. Obviously if you're not going to put a little pressure on there is no reason in having a four layer compression bandage. You might as well just put a little crepe on. You've got to try and get that balance.'

Participant 6 took a very evidence based approach and referred to national benchmarks and guidelines as the main driver for care within the practice area, without reference to other parts of the process.

Throughout the interviews all participants referred to their own positive experiences, and only participant 3 identified a personal negative experience and was reluctant to discuss it. All of the participants gave at least one incident of poor practice in other nurses.

A process of reflection as a means for changing or developing practice was referred to by participants, 3, 4 and 7. The reflection takes place after the event and involves reflecting on 'what I have done, would I have done it differently, what I could do to improve it and what did I say that I shouldn't have said?' (participant 3). Participant 4 was the only one who kept a portfolio which mostly involved reflecting on positive experiences and reflecting into what other outcomes could have taken place.

Influencing practice change and development

This category identifies the influences that participants identified as impacting on their practice change and development. This category included both local and national influences. The sub categories that arose from the data are audit, research and evidence based practice, values, other professionals, programmes of study and courses.

AUDIT

Audit was identified as a driver for improving nursing practice and the service given to patients. The audits were initiated both across the healthcare provider organisation and within departments. Outcomes of the audits were unconditionally accepted by all participants that cited examples. Examples of audit undertaken on cross healthcare provider organisation nursing practices include staff attitudes to and knowledge of to pain relief (participant 4), and the alcohol pathway (participant 5). Participant 3 highlights how the service can be improved through audit by citing the example of an audit undertaken on 100 patients to try and reduce the number of missed appointments by children and parents. It was found that the appointments were given out too early and a volunteer was brought in to ring around to remind parents of their appointment. This initiative has increased the attendance by 10%.

None of the participants audited their own specific nursing practices and participants 1, 2 and 6 did not mention audit at all.

RESEARCH AND EVIDENCE BASED PRACTICE

Participants' use of research to underpin their practice varied from not referring to any (participants 1, 3, 5 and 7), to undertaking small scale studies in the department (participant 2):

> 'Difranol, is applied for psoriasis, it's from a tree. It burns good skin so our, actually no it has changed, but I was part of that change. We used to put the difranol on the psoriasis to the plaque and you had to be careful not to put it on other skin. So when we put the difranol, we used to talc them all over

and put these stockinet things on. I used to end up with terrible chests, coughing the talcum powder all of the time. Imagine doing five or six patients a day, five days a week. It gets on your chest. So what we did was a study to see whether there was burning or smudging by not having the talcum powder, but just putting the stockinet on. It was an informal study that we did over a period of a month or something like that over several different patients. We found that there was no difference and so we got rid of the talc. So that part of it hasn't changed but the actual application has.'

Other participants (2 and 4) used published research to inform new ways of performing practice. Participant 4 researched privacy and dignity, and suggested that a clothes peg was used on curtains around beds to prevent patients being disturbed during procedures such as bed bathing.

Participant 6 identified national guidelines as a source for providing evidence on which to base care:

'Even when we have relatives come in and ask why you are doing this and that, we can show them the NICE guidelines and we can say this is the latest research.'

None of the participants distinguished research from evidence.

VALUES

Personal values and their influence on nursing practice were identified by participants 1, 4 and 5:

'For me it has developed through my own ethos and my own empathy. Old fashioned words from years ago really. Even through my own religion, it's something that communication wise I feel strongly that we need to embrace this. I think this has developed over my 15 years' experience, learning how to or meeting different people with different nationalities, different backgrounds.'

Participant 4 talked about being a 'traditionalist' at heart and reinforced these values through the way that he influenced the nursing practice of others.

Participant 5 identified how she would wish to be treated:

> 'Personally I treat people like I want to be treated and I expect people to treat my family and friends the same, so that sort of way I feel it's inbred'

This value was reflected in a later statement on bed making.

OTHER PROFESSIONALS

Participants 1, 3, 4, 5 and 7 identified significant others in the workplace who impacted on their practice. This was either by identifying the underpinning theory behind the practice, providing them with a more effective way of performing the care or having a role model from previous posts when influencing practice.

The example below highlights how a specialist nurse (Participant 1) was able to fill in the gaps of underpinning knowledge when struggling with a patient's pressure sore:

> 'Yes and again reiterated I suppose the physiology of what had happened to the deep underlying problem that the patient had. You know the stages that a pressure sore went through. I mean we learn all of that through nurse training, and if you are fortunate enough through your training to see a severe pressure sore, that's all very well but again if you do, you may only be dealing with qualified staff who aren't quite sure on how to deal with it. So effectively I felt that the likes of the specialist nurse was more effective to the point without us having to be wandering in a quandary.'

Participant 3 also identified how her practice developed within a new role through support of colleagues in the clinical area:

> 'Obviously I needed training in this procedure, so I had to go with the vitro retinal nurse and also nurses who could graduate, for example our clinical manager. So I got their spin, I knew what to say and I just adapted it myself.'

Participant 4 identified the impact of role models when influencing future practice:

> 'My first post when I qualified I had a very traditional ward sister, you know everybody was called staff or staff nurse it wasn't a first name basis. I found that there was a lot more respect there. There was a better attitude and people did know your boundaries. The ward was run really well, the patients were well looked after. Then I went onto another ward, which was actually in a different healthcare provider organisation, and it worked completely differently. OK it might have been a better atmosphere, more friendly, but I just felt that people were just trying to get away with what they could, because they didn't know what the boundaries really were.'

COURSES, PROGRAMMES OF STUDY

An unexpected feature that emerged from the interviews was that all seven participants place a high value on sharing their knowledge with others, particularly the knowledge gained as part of further study on their part. Participant 1 wanted to set up a 'special board with a monthly display' and contact details for any queries. Participant 2 had written and was involved in the teaching of a work based module on Doppler measurement. Participant 4 had refurbished a part of the ward with a view to creating a study area for student nurses and he was involved in teaching on a regular basis. Participant 5 attended a dementia training course and uses the information on a regular basis to raise awareness of dementia patients' behaviour.

Programmes of study were not identified as drivers for change in practice. They were identified as raising awareness, promoting a questioning approach (participant 3).

Rituals and routines

This category explores how rituals and routines impact on practice change and development. The sub categories include a definition of a true ritual, the nature of routines within nursing practice and any nursing rituals that are still carried out.

Only participant 2 could give the definition of a true ritual:

> 'I think nurses need some rituals. A little bit of myth and ritual. Like you know putting a poultice on, a leaf picked at the full moon by a virgin with cross eyes. It actually does the trick but because you don't know which bit works, you just do the whole thing. I suppose we don't do it as much as we used to. But there is always that element there because you have to do things. I think we have eliminated an awful lot of rituals. People have an expectation of you.'

All participants could identify daily routines that they take part in and routines are the backbone of the working day. All participants were able to identify examples of nursing routines; these routines are very often linked to classic task allocation of nursing practice. They can also be classified as poor practice. Participant 5:

> 'The whole shift tends to be a routine, you will have a routine from when you start your shift to the end of your shift and you just have to deal with everything that comes along during that shift like. Any unexpected poorlies, relatives and everything you just fit in. You go in on an early shift and your routine is you do your controlled drugs, check your control drugs, then do your beds, then make sure the bloods are all in and do your breakfasts, then your drug round. Then the patients are sorted. There are dinners, then obs. I think every shift has a routine; you just deal with everything that comes.'

Some routines can be examples of nursing rituals and examples of this came from participant 1 who identified the routine of having all nursing practice related to patients' hygiene completed within the morning shift. Participant 2 identified the practice of wrapping leg ulcers by using the same trolley and moving from patient to patient.

Participant 2 gave an accurate definition of a nursing ritual:

> 'A nursing ritual is something that you do, that is not research based. It's something that you have always done and what we are always going to do. It's not for the benefit of the patient, more for the benefit of the nursing staff.'

A classic example of a nursing ritual was given by participant 6 who was discussing nursing rituals:

> 'No I've just gone round and done some observations round the back and a lot of the patients are only on twice weekly observations. And I queried it why are you doing this as the patient is supposed to be going home tomorrow. You can turn round and say that it is and the consultants will also guide if they want the observation continued on patients. Legally it is actually a medical decision to turn round and say no we don't want the observations.'

Thoughts:

The memo is too big, need to consider whether the examples are needed, how helpful are they when they can be accessed easily from NVivo?

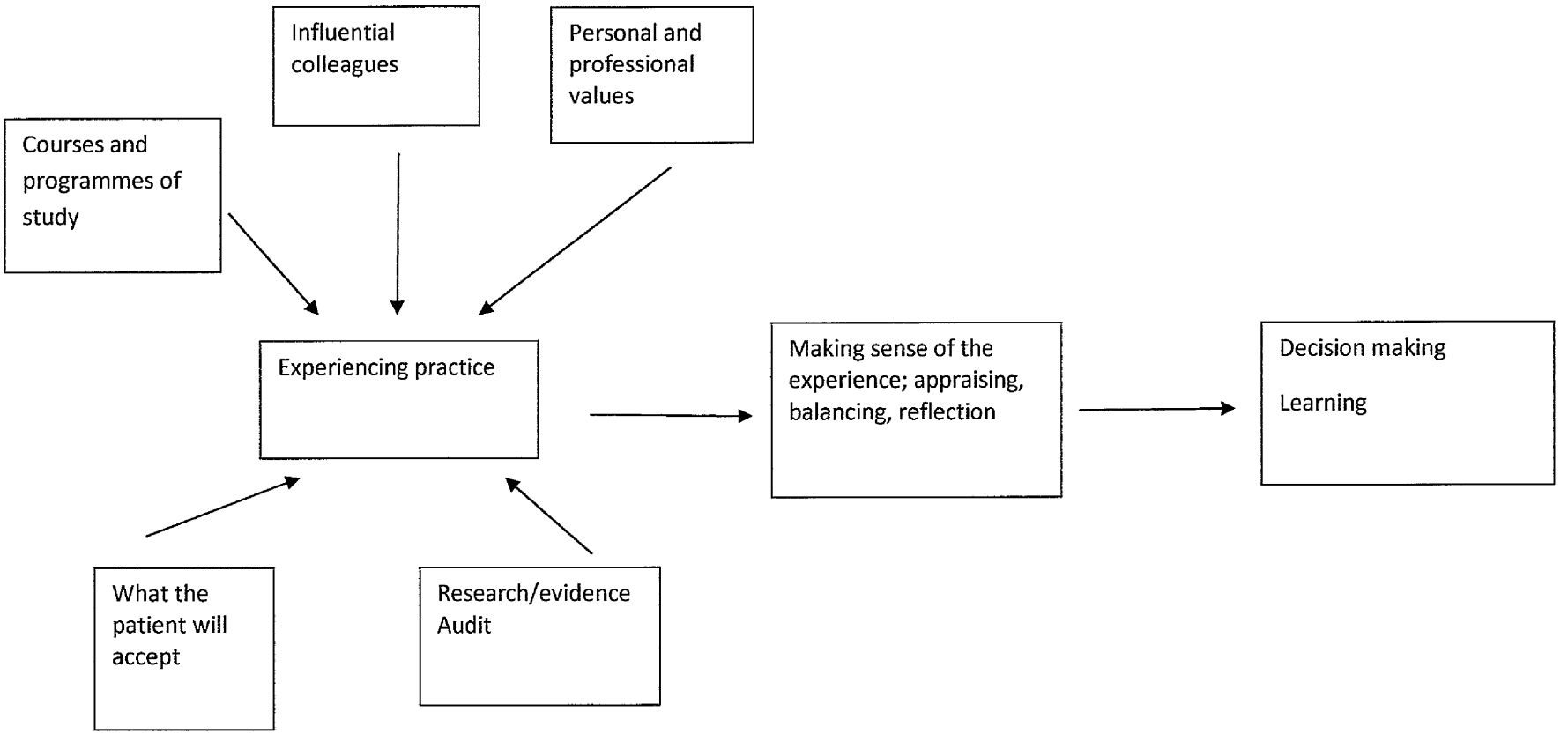
What is the nature of practice that is changing? Need to be clear as one of the research questions. The nature of practice change needs more definition.

The experience that participants have in practice seems to be crucial and can be seen across several categories; the overall actual experience of practice that is changing and it is the experiences that participants have in practice impact on the change. Are the influences on practice influencing the experience that the nurse has in practice? Should experience be a category in its own right?

Not all participants responded similarly to the factors that influenced practice. What does this mean in terms of their approach to practice change?

There is nothing directly in the data that highlights the relationship of routines and rituals to promoting or inhibiting practice change and development, but rituals were still evident in nursing practice, obviously still important, so what part do they play?

Appendix 8: Diagram to illustrate the personal process of practice change and development



Appendix 9: Ethical approval from Wirral Research Ethics Committee

When telephoning please ask for:
Mrs Barbara Parry

Wirral Research Ethics Committee
Operational Management
Arrowe Park Hospital
Upton, Wirral
CH49 5PE

Tel: 0151 604 7247
Fax: 0151 605 0948
Email: barbara.parry@whnt.nhs.uk

Your Ref:
Our Ref: 88/03

18th November 2003

Ms Linda Meredith
Associate Dean
Business Support, CIT
& Resources
Chester College
School of Nursing
Midwifery & Social Care
Parkgate Road
Chester
CH1 4BJ

Dear Ms Meredith

Re: **An Exploratory Study to Develop a Repertory Grid that will be used to investigate how Nurses Construct their World of Changing Practice**

Thank you for your letter dated 7th November 2003 enclosing

- A lay summary
- A diagram identifying the phases of the proposed research
- More information on the nature of the repertory grids and their uses
- Clarification on the sample and size

I am pleased to inform you that the above study has been approved by the Wirral Research Ethics Committee.

As usual for studies of this nature the Committee's approval will initially remain valid for 12 months (from the date of this letter) and is conditional upon you:

- Informing me immediately should it be necessary for any changes to be made to the protocol, or should the study or your involvement with it be terminated early for any reason

- Submitting a report of progress with the study nearing the end of the 12 month period if an extension of the Committee's approval is required. This report should include details of the number of patients recruited and give some indication of the likely completion date
- Providing the Committee with details of any serious adverse events that occur.

Please let me know as soon as the study has been completed and arrange to provide the Committee with a copy of the findings (or a summary of these) in due course.

Yours sincerely

Dr D J Manning
Chairman
Wirral Research
Ethics Committee

Appendix 10: Ethical approval from University of Chester Research Ethics Committee

RE/MAN

University of Chester

School of Health and Social Care

12 October 2006

Chester Education Centre
Parkgate Road
Chester
CH1 4BJ
Direct Line 01244 383688
Fax 01244 381090

Mrs Linda Meredith
Associate Dean
School of Health & Social Care
University of Chester

Dear Linda

I am pleased to inform you that Professor Ellis has taken chairman's action on behalf of the Research Ethics Sub Committee of the School of Health & Social Care to approve your project "Nurses understanding of 'Practice Change and Development', influencing factors and resistance to change ".

Approval is subject to the following conditions:

1. That you provide a brief report for the sub-committee on the completion of your project.

2. That you inform the sub-committee of any substantive changes to the project

May I take this opportunity to extend the best wishes of the Sub Committee and its Chairman for the successful completion of your project.

Yours sincerely

Marilyn Norbury
Secretary to the Sub Committee

cc File

Appendix 11: Ethical approval from Cheshire North & West Research Ethics Committee

NHS
Cheshire North & West Research Ethics Committee
Cheshire West PCT
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ

Telephone: 01244 650334
Facsimile: 01244 650333

2 February 2007

Mrs Linda Meredith
Associate Dean Business Support, Resources and CIT
University of Chester
School of Health and Social Care
Parkgate Road
Chester
CW124FL

Dear Mrs Meredith

Full title of study: NURSES UNDERSTANDING OF PRACTICE CHANGE AND DEVELOPMENT, INFLUENCING FACTORS AND RESISTANCE TO CHANGE

REC reference number: 06/Q1506/131

The Research Ethics Committee reviewed the above application at the meeting held on 17 January 2007.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to complete Part C of the application form or to inform Local Research Ethics Committees (LRECs) about the research. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Application		02 January 2007
Investigator CV		02 January 2007

Protocol		02 January 2007
Covering Letter		02 January 2007
Interview Schedules/Topic Guides		02 January 2007
Letter of Invitation to participant		02 January 2007
Participant Information Sheet		02 January 2007
Participant Consent Form		02 January 2007
letter Univ of Chester		12 October 2006
letter Wirral REC		18 November 2002
CV Dr Stephen Fallows		

Research governance approval

You should arrange for the R&D Department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

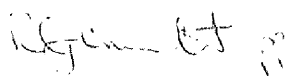
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1506/131	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



Mr Jonathan Deans, FRCS
Chair Cheshire LREC

Email: rob.emmett@cwpct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
Standard approval conditions

Cheshire Research Ethics Committee

Attendance at Committee meeting on 17 January 2007

Committee Members:

Mr Jonathan Deans, FRCS	-	Chair
Dr Lenny Thornton	-	Consultant Member
Mrs Jan Makinson	-	Lay Member
Mrs Jean Welch	-	Lay Member
Mrs Ann Williams	-	Lay Member
Mrs Janet Petty	-	Nurse Member
Dr Sue Kaney	-	Consultant Member
Mrs Pam Rushworth	-	Pharmacist Member
Dr Neil Thomas	-	GP Member

Appendix 12: NHS Trust Approval to Proceed

Cheshire and Wirral Partnership NHS
NHS Trust

Academic Unit
St Catherine's Hospital
Church Road
Birkenhead
Wirral
CH42 0LQ

Tel: 0151 604 7333
Fax: 0151 653 3441

3rd April 2007

Dear Mrs Meredith

Re: NHS Trust Approval to Proceed

Project Reference: 0555-HSR

Project Title : Nurses Understanding of Practice Change and Development, Influencing Factors and Resistance to Change.

I am pleased to inform you that the above project has been discussed and approved. You may now proceed with your research in the following locations:

Early Intervention Teams across the Cheshire and Wirral Partnership patch (Chester, Wirral, Crewe and Macclesfield)

Please take the time to read through this letter carefully and contact me if you would like any further information. You may need this letter as proof of your approval.

Honorary Research Contracts

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that directly affects the quality of their care, should hold honorary NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care,* 2005

Research Governance

The Research Governance Sponsor for this study is the University of Chester. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv
For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Confidentiality and Information Governance

All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must by treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

NRR http://www.nrr.nhs.uk/

We are required by DH to report all non-commercial research carried out within the trust to the National Research Register (NRR). In order to comply, we will prepare a summary extracted from the information you have already provided to us. These details are published on the internet. If you wish to receive a copy of the NRR information for your study, please contact me.

Protocol / Substantial Amendments

You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details

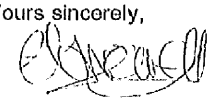
You will be required to produce a short electronic progress report on completion or annually as a minimum. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw approval.

Final Reports

At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,



Helen Newell
Effective Clinical Practice Officer

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